County of San Bernardino

Department of Behavioral Health

CULTURAL COMPETENCE PLAN UPDATE

March 2004

Introduction:

The state of California continues to experience population growth in various ethnic groups. Population growth has presented several cultural and linguistic challenges. According to the Surgeon General's Report, Mental Health: Culture, Race and Ethnicity 2001 and the Little Hoover Commission 2000, "minorities receive treatment at a rate that is even lower than that of the general population. Ethnic minority populations appear to bear a greater burden from unmet mental health needs and suffer a greater loss to their overall health and productivity". "As California's population has grown in size and diversity, the mental health system has strained to keep up with the need for care (Little Hoover Commission)".

Table 1
County of San Bernardino
Population Increase: 1980-2000

Year	Population	% Increase Over Period
1980	895,016	30.8%
1990	1, 418,380	58.5%
2000	1,709,434	20.5%

Source: 1980, 1990 and 2000 Census

Against this backdrop, the San Bernardino County Department of Behavioral Health is also experiencing a dramatic growth with various ethnic groups.

Table 2
County Population by Ethnicity

Ethnicity	Number	Percent
White	752,222	44.0%
Hispanic	669,387	39.2%
Black	171,461	10.0%
Asian	106,702	6.2%
Other/Unknown	9,662	0.6%
TOTAL	1,709,434	100.0%

Source: 1980, 1990 and 2000 Census

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Department of Behavioral Health

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Summary Analysis

San Bernardino County Department of Behavioral Health is facing similar cultural and linguistic challenges. It is the intent of this cultural competency plan to address access barriers, poor penetration rates and to develop a system of care that incorporates appropriate cultural and linguistic services by reviewing, evaluating and modifying the current system. The department's efforts will include:

1. Aggressive recruitment/retention of bilingual/bicultural staff (based on budget availability)
2. Training protocols and curriculums to address needs of ethnic groups.
3. Research.
4. Community-based outreach/engagement strategies to increase delivery of services to underserved population in order to increase penetration rates (volunteers, grassroots faith based organizations should be included).
5. Community forums for input in the development of appropriate cultural and linguistic services
6. Maintenance of the Cultural Competency Committee to foster and implement state requirements on cultural competency.
7. Identification and Participation in interagency committees in order to foster cultural competency.

DATA INTRODUCTION

The information on mental health services used in this report is from fiscal year 2001-2002, and includes U.S.A census information of 1990 and 2000. The San Bernardino County Department of Behavioral Health Research and Evaluation Unit created reports based on information of fiscal year 2001-2002.

Data on mental health services is from San Bernardino Information Management On-line Network (SIMON). The California Department of Mental Health has also made data available on mental health services in each county through the information Technology Web Services (ITWS). The ITWS data includes:

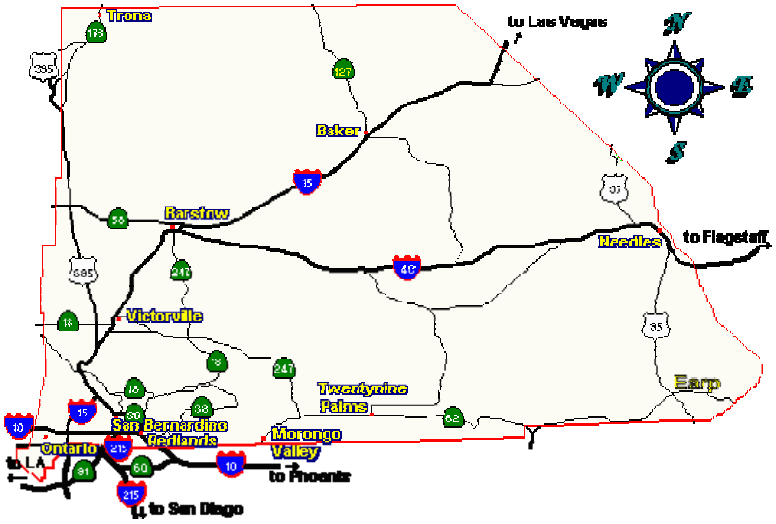
1. Source Data and Penetration rates by Race/Ethnic Group for fiscal year 1999-00
2. Source Data and Penetration rates by Race/Ethnic Group for fiscal year 2000-01
3. Source Data and Penetration Rates by age group for 1999-00
4. Source Data and Penetration Rates by age group for 2000-02 (Attachment 1)
5. Overview Comparison of FY 1999-00 to 2000-01 (Attachment 2)

Part I:
Data Analysis
and Objectives

COUNTY GEOGRAPHIC PROFILE

The County of San Bernardino is located in Southern California approximately sixty miles inland from the Pacific Ocean and its southern border is 100 miles north of Mexico. It borders on the metropolitan areas of Los Angeles and Orange Counties. The county consists of three unique, geographic areas: the Inland Valley, the San Bernardino and San Gabriel Mountains, and the Mojave Desert. The County of San Bernardino is the largest county in land area in the continental United States containing over 20,000 square miles. It has land area larger than the states of Rhode Island, Delaware, Massachusetts, New Jersey, Maryland, Hawaii, Connecticut, New Hampshire and Vermont. The county comprises 12% of the California's land area and stretches on the west border from Pomona in Los Angeles County eastward to the Colorado River and the states of Arizona and Nevada. It extends from Anaheim in Orange County in the southwest to Death Valley and nearly to Las Vegas, Nevada in the northeast. Having 1,709,434 residents (Census 2000), the population of the County of San Bernardino exceeds that of Alaska, Hawaii, Nevada, Maine, Rhode Island, New Hampshire, Wyoming, Montana, Idaho, Delaware, North Dakota, South Dakota and Vermont.

Map of San Bernardino



Regional Information:

The County is split into four regions for MHP planning purposes, each with roughly half a million residents: the West Valley, the East Valley, the Central Valley, and the Desert/Mountain.

Most of the land mass is contained within the Desert/Mountain region, which borders Arizona, Nevada, and the counties of Inyo, Kern and Riverside. It includes the cities of Adelanto, Apple Valley, Baker, Barstow, Big Bear, Big Bear Lake, Big River, Hesperia, Hinkley, Joshua Tree, Lenwood, Lucerne Valley, Morongo, Needles, Phelan, Trona, 29 Palms, 29 Palms Base, Searless Valley, Victorville, Wrightwood, and Yucca Valley.

The West Valley borders Riverside, Orange and Los Angeles Counties and includes the cities of Chino, Chino Hills, Fontana, Montclair, Ontario, Rancho Cucamonga, San Antonio Height, and Upland.

The East Valley of San Bernardino County borders Riverside County and includes the cities of Blue Jay, Crestline, Highland, Lake Arrowhead, Loma Linda, Mentone, Muscoy, Redlands, Rim of the World, Running Springs, San Bernardino, Twin Peaks, and Yucaipa.

The Central Valley includes the cities of Bloomington, Colton, Grand Terrance and Rialto.

Each region is composed of county operated clinics, contract providers, specialized programs and have a Resource Service Center. Each Resource Service Center provides services for adults, older adults, children and families. The services include, but are not limited to medication support, individual therapy, groups, case management, intensive case management, crisis intervention, walk-in clinics, and homeless services. School based outpatient and CalWORKS services are also located in all regions. In addition each region has a Recovery/Club House run by clients. In an attempt to have a seamless system of care, DBH has integrated Drug and Alcohol services in all the regions. Specialized programs are Children System of Care, Homeless, Hospital Diversion,

Forensics, and Intensive Day Treatment programs. These services are available to all beneficiaries but are not physically located in all the regions.

Distance:

San Bernardino is a commuting county, with approximately 20% of the labor force traveling an average of 21 miles one way to work. More than 138,000 residents commute more than fifty miles to and from work on a daily basis. There are 11,339 miles of streets, roads and highways throughout the County. Most daily movement of traffic occurs on the interstate freeways that often crowded, especially at peak driving times. Interstate 10 is the primary highway that stretches the length of the valley. Most of the roads are concentrated in the southeastern part of the County. Interstates 15 and 215 extend through the mountains at the Cajon Pass. Interstate 215 is the only major road from the valley to the high desert communities of Victorville, Hesperia, Adelanto, and Barstow. Beyond Barstow I-15 continues for 150 miles to Las Vegas while I-40 breaks off to Arizona. Several state highways circle the mountains and extend to remote desert communities.

General Public Transportation:

Local public transportation is provided by Omnitrans. Omnitrans have 40 routes, with fares ranging from free for children under 4 to $.65 for senior/disabled and $1.10 for full fare. Monthly bus passes range fro $15 to $35. MARTA provides bus service in the mountain communities and has offices in the communities of Bear Valley and Rim of the World. Other public transportation in this region is provided by Greyhound (nationwide bus service) and neighboring transit services such as RTA (Western Riverside County), Foothill Transit (San Gabriel Valley, Los Angeles County), and LACMTA (Los Angeles County). Amtrak provides passenger rail service, with stations located in San Bernardino and the desert cities of Barstow, Needles and Victorville. The San Bernardino Line of the Metrolink commuter rail service provides passenger service to Los Angeles. This 56.2 mile long rail serves 7,500 daily passengers and has stations in the cities of San Bernardino, Rialto, Upland, Fontana, Montclair, and Rancho Cucamonga. In addition,

the Riverside Line has a station in Ontario. Dial-A-Ride and Access services are available to seniors and persons with disabilities within the East and West Valley. The county has a number of private and municipal airports; there are 17 such facilities. Ten of these small airports are spread throughout the Desert/Mountain region. A busy international airport is located in the West Valley city of Ontario. Two former Air Force Bases are also within the County.

Regional Transportation Information:

West Valley Region – The West Valley Region has an excellent rail-service and is served by the Union Pacific and Burlington Northern Santa Fe Railroads. In addition MetroLink and Amtrack serve the region, which provide local and national passenger services. The regions main highways are Interstate 10, 15, 60, and 210. There are two major airports, Ontario International Airport and Cable Airport. Cable Airport is the world's largest privately owned airport with over 100 acres and serves as a home base for 450 private and corporately owned aircraft. Ontario International Airport ranks among the top one hundred busiest airports in the world and is one of the fastest growing in the United States. This region has good public transportation provided by Foothill Transit, Greyhound and other non-profit transportation systems.

Central Valley Region. - The Union Pacific, Burlington Northern Santa Fe and Southern Pacific Railroads serve the Central Valley Region. The region's main highways are Interstate 10, 15, 60, 91, and 215. The nearest passenger airport is the Ontario International Airport. The airport is about 20 miles away from most of the Central Valley cities. The Municipal Airport is located in the city of Rialto. The Rialto Municipal Airport serves private/recreational pilots and will accommodate corporate jet aircraft. The Rialto Airport is also home to the County of San Bernardino's Sheriff's Aviation Unit. This region has good public transportation provided by Foothill Transit, Greyhound and other non-profit transportation systems.

East Valley Region. - The Union Pacific and Burlington Northern Santa Fe Railroads serve the East Valley Region. In addition MetroLink, and Amtrack serve the region, which provide local and national passenger services. The region's main highways are

Interstate 10, 15, 30/330, 91 and 215. The Ontario International Airport is within 45 minutes of any city in the East Valley region. The San Bernardino International Airport is located in the City of San Bernardino. This region has good public transportation provided by Foothill Transit, Greyhound and other non-profit transportation systems.

Desert/Mountain Region - The Union Pacific and Burlington Northern Santa Fe Railroads serve the Desert/Mountain Region. In addition, Amtrak serves a couple of the cities in this region. The region's main highways are Interstate 15, 18, 62, 127, 138, 330, and 395. The Ontario International Airport is within 45 minutes to two hours away from cities in this region. The region has nine municipal airports. This region has limited public transportation access.

DBH Transportation Assistance Program:

Each region has General Service Workers who provide transportation for clients to attend their outpatient appointments. This service is designed to facilitate access to our services and to provide continuing care for our clients. In addition, we have a Transportation Unit for special populations (e.g. 5150, etc) available for all regions.

SOCIO-ECONOMIC PROFILE

Primary Support:

According to the 2000 census, San Bernardino County's population is 1,709,434 residents. Nearly one-fourth of all households in the county were lower income households in 1990. While the median income increased between 1990 and 2000 (by $10,127 or 27%), lower income groups may not have experienced comparable income growth.

The 2000 Census identified 528,594 households in the county, and increase of 62,717 households from the 1990 Census count of 465,877 households. The 2000 average household size was 3.15 persons. This figure represented a slight decrease compared to the 1990 average household size of 3.4.

San Bernardino County has 721,185 residents in the labor force. Primary support for San Bernardino County according to the 2000 Census is as follows:

Table 3
Total Labor Force: 721,185

Area	Number of People Employed	Percentage
Construction	49,517	7.5%
Manufacturing	84,166	12.7%
Retail Trade	84,460	12.8%
Professional, Scientific, Management	50,726	7.7%
Educational, Health and Social Services	140,063	21.2%
Unemployment	59,913	8.3%

Source : U.S. Census Bureau, Census 2000

The data on table 2 represents the six (6) major primary industry source of income. Primary support for the County has changed from 1998, where Agriculture was a major support for the County's economy. According to the 2000 Census Agriculture has drastically reduced and Education, Health and Social Services has increased from 96,000 workers in 1997 to 140,063 in 2000 with an increase of approximately 44,000.

Table 4
Households by Income Levels

Income Category	Number	Percent
Extremely Low-Income/Less than $14,999	82,792	15.7%
Low-Income/Less than $24,999	68,754	13%
Moderate-Income/Less than $34,999	66,513	12.6%
Middle-Income/ 74,999	195,928	37.1%
High-Income/ Above 75,000	114,852	21%

Source : U.S. Census Bureau, Census 2000

As indicated in the table three, 37.1% of the households are in the middle-income level. The second largest income level is the high-income level with 21% of the population earning income above $75,000.

Regional Information – Primary Support, Average Income Levels and Employment Data

Table 5
Primary Support, Average Income Levels and Employment data by Regions:

Description	Desert/ Mountain	East Valley	Central Valley	West Valley
Employed civilian population 16 yrs. And older	102,562	151,872	63,366	277,285
Industry in which they're employed				
Agriculture, forestry, fishing, hunting and mining	0.9%	0.8%	0.6%	0.9%
Construction	7.9%	7.6%	7.3%	6.8%
Manufacturing	8.8%	8.8%	14.9%	16.2%
Wholesale trade	2.6%	3.4%	4.7%	5.1%
Retail trade	13.8%	11.7%	13.8%	12.5%
Transportation/warehousing, utilities	8.2%	5.5%	7.8%	6.8%
Finance, insurance, real estate, and rental and leasing	5.2%	5.4%	4.4%	6.4%
Professional, scientific, management, administrative, and waste management services	6.3%	8.3%	7.0%	8.1%
Educational, health and social services	21.4%	27.1%	21.8%	18.1%
Arts, entertainment, recreation, accommodation and food services	9.6%	8.1%	5.7%	6.6%
Public administration	7.1%	5.9%	5.2%	4.8%
Other	8.2%	7.4%	6.9%	7.6%
TOTAL	100.0%	100.0%	100.0%	100.0%

Number of Households	100,003	129,962	48,395	190,291
Sources of Household income				
Percent of households with earnings	75.0%	79.5%	85.1%	88.9%
Households with Social Security income	29.8%	23.4%	19.7%	16.4%
Description	**Desert/ Mountain**	**East Valley**	**Central Valley**	**West Valley**
Households with Supplemental Security	6.8%	6.4%	6.4%	4.5%
Households with public assistance income	7.5%	8.4%	7.8%	4.3%
Households with retirement income	20.8%	16.5%	14.7%	12.1%
Median Household Income	$36,323	$38,168	$39,933	$52,915
Minimum median city household income	$25,488	$25,635	$34,106	$40,797
Maximum median city household income	$50,488	$60,826	$53,649	$78,374
Total population 16 years and older	212,587	283,070	115,559	461,802
Employment status among those 16 and older				
Employed	52.2%	54.5%	54.9%	60.1%
Unemployed	5.1%	5.3%	5.8%	4.5%
Not in labor force	42.7%	40.2%	39.3%	35.4%

Source : U.S. Census Bureau, Census 2000. Prepared by Research and Evaluation

The largest industry in the Desert/Mountain region is Education, Health and Social Services. It has the largest number of people on SSI and retirement income in the County and has the lowest minimum median city household income. They have the highest number of people not in the labor force. Many people that retire move to this region because housing is less expensive.

The largest industry in the West Valley region is Education, Health and Social Services. It has the largest number of people employed in the County and also has the highest median income. Therefore, they have the lowest number of people on public assistance.

The largest industry in the East Valley region is Education, Health and Social Services. It has the largest number of people public assistance and has the 2nd largest number of people on SSI. It is the 2nd highest number of residents not in the labor force in the county.

The largest industry in the Central Valley region is Education, Health and Social Services. This region has the lowest number of people residing in the county. It has the

largest number of people unemployed. Therefore, they have the largest number of people on public assistance.

WELFARE CASELOAD:

The Welfare Reform in California had a positive impact by reducing caseloads. According to the California Department of Social Services the total AFDC/TANF caseload in 1995 for San Bernardino County was approximately 65,000. In 1999 the caseload dropped to approximately 45,000 resulting in a 30% reduction. The overall decrease in caseloads is reflective in the Ethnic categories as well. The total number of CalWORKs Cash Grant applications for October 2003 was 3,156. 1,611 were approved and 2004 were denied.

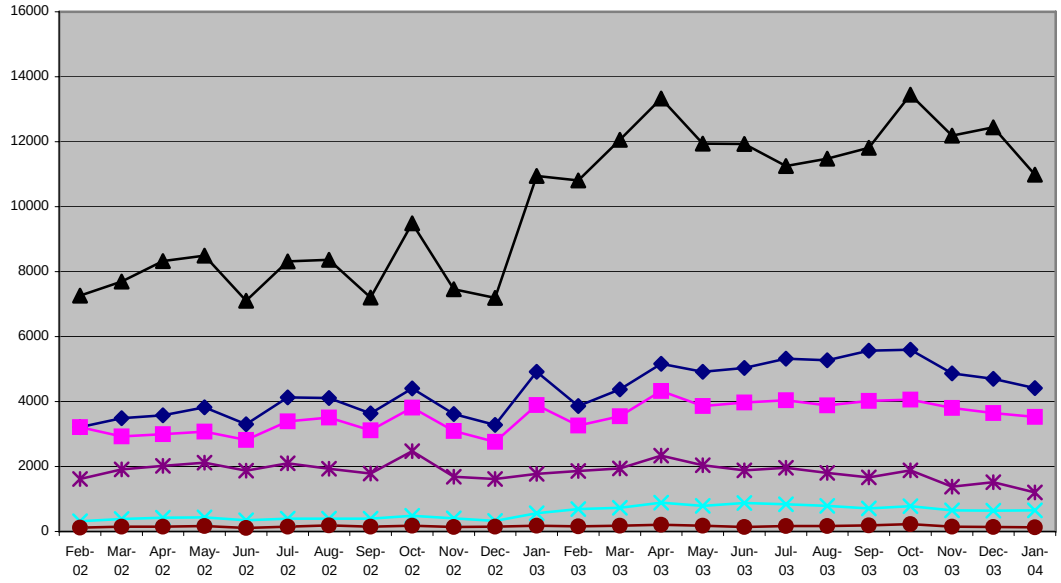
The county of San Bernardino has had an increase on Children services referrals. An 8.3% increase in referrals received between 1999 and 2000. In 2001 referrals increased 6.4% from 2000. In 2002 referrals show a 2.44% increase over 2001, which represents a significantly lower rate of increase over the previous two years. Children involved in referrals are almost evenly split by sex. This ratio has remained constant over the years. The percentage of children age 8 and younger has increased slightly from last year to 53%. In 2001 52% of children reported have been age 8 or younger.

Table 6
Children Services Referrals
By Ethnic Breakdown

Ethnicity	1999	2000	2001	2002
White	40%	38%	36%	35%
Black	17%	17%	17%	16%
Hispanic	32%	33%	34%	34%
Asian/Pacific Islander	1%	1%	1%	1%
Native American	<1%	<1%	<1%	<1%
Not Available	9%	10%	13%	15%

Dept. of Transitional Services 2002

Table 7
Welfare System Information
Transitional Department



Dept. of Transitional Services 2002

Analysis:

The chart above illustrates the Intake Caseload Trend. Some of the highlights are:

- The Medi-Cal caseload has surpassed 100,000 for the first time
- The Child Care caseload (Intake and Continuing) continues to decline.
- The General Relief Intake Continuing caseload has dropped for the first time in almost a year.

Table 8
Welfare Case Load by Region 2002/2003

Region	Welfare Caseload
West Region	4,736
East and Central Region	20,100
Desert/Mountain Region	9,216
Total	34,052

Dept. of Transitional Services 2002

The average monthly caseload of Single Parent and/or Disable Parent is 19,719. The average caseload of Two-parent household is 2,296 and Child only caseload is 10,548. 1,380 cases are under the Safety Net category.

Child abuse reports filed in 1999 for San Bernardino County were 47,565. The total 2002 First entry to the Child Welfare Supervised Foster Care system was 1,759 and 532 reentries.

EMPLOYMENT DATA:

As indicated in the table three, 37.1% of the households are in the middle-income level. The second largest income level is the high-income level with 21% of the population earning income above $75,000.

Table 9
Total Labor Force: 721,185

Area	Number of People Employed	Percentage
Construction	49,517	7.5%
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Retail Trade	84,460	12.8%
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Educational, Health and Social Services	140,063	21.2%
Unemployment	59,913	8.3%

Source : U.S. Census Bureau, Census 2000

The Desert/Mountain region has the highest percentage of people not in the labor force (42.7%). This is mainly due the large number of retired residents living in the region. The lowest percentage of people not in the labor force is in the West region with 35.4%.

OTHER RELEVANT CHARACTERISTICS:

Group Homes

According to the "Mapping a System of Children's Group Homes in San Bernardino County" report San Bernardino County is the largest county in the State; it is not surprising that there are 90 group homes in the County receiving referrals from County's Probation, Children Services, Behavioral Health Department and agencies from other counties such as Los Angeles, Riverside and Orange. The number of children in-group home placement varies by placing agency. The Probation department has placed between minimum 270 and maximum 640 youth per month in-group homes during the last 14 years. The Department of Children Services has placed between minimum 190 and

maximum 350 youth per month during the last 11 years. The Department of Behavioral Health has placed approximately 40 youth per year since 1996. Although very few of the children/youth in placement receive mental health services, it has been estimated that at least half of the children in foster care would benefit from such services. The majority of youth in-group/foster home placements are males. DBH signed a Memorandum Of Understanding with the Department of Children Services to evaluate children in foster home placement for Mental Health needs. At most, half of the San Bernardino youth in placement are located within the county, while the rest are in-group homes in other California counties or even out of state. DCS children are the youngest on average (13 years old), while those placed by DBH and Probation is a bit older (15 and 16 years old).

More than two thirds of the population resides in the southeastern corner or valley region of the county. Not surprisingly, that is also where most of the group homes are located. However a few group homes are also located in what is referred to as the "high desert cities of Victorville/Hesperia/Apple Valley, etc. The largest cluster of group homes are within the cities of San Bernardino and Rialto, with a smaller cluster occurring in the cities of Redlands/Yucaipa. The majority of the group homes are small, comprised of six to nine beds. There are only a few group homes, which have more than 50 beds.

Children Services

The Department of Children's Services Year To Date report, states that as of January 14, 2003 the department of Children Services was providing on-going services to 6991 cases. The program breakdown is 239 in Emergency response, 1107 in Family Maintenance, 2137 in Family Reunification and 3508 in Permanent Placement. The average number or open cases per month has shown a decline over 2002 ranging from a high of 7403 in June 2002 to a low of 7118 in March 2002. The December 2002 average was 7172.

Foster Homes

Table 10
Foster Homes by Type

Foster Home Type	Count
Emergency Shelter (backup Home)	16
Fost-Adopt	230
Fost-Adopt Pending	7
Foster Home Pending	2
Medically Fragile	6
Open	263
Other	2
Special	57
Youth Services	11
TOTAL	594

Department of Children's Services Year to Date Report (1/2003)

Foster Homes are located throughout the county. The largest concentration of Foster Homes is located in the cities of Rancho East including Rialto, Bloomington and Fontana (22%). Followed by 18% in the high desert including Victorville, Hesperia, Lucerne and Apple Valley.

Table 11
Percentage of Children in Placement by Ethnicity

Ethnicity	Percentage in Placement
Asian/Pacific Islander	1%
Black	26%
Hispanic	31%
Native American	<1%
White	41%
Not Available	<1%

Department of Children's Services Year to Date Report (1/2003)

Population Trends

Fontana is the 9th fastest growing city in the U.S. over a two-year period according to the 2000 US Census Bureau. Between April 1, 2000 and July 1, 2002 Fontana grew by 11.4%, adding 14, 669 persons. Another city that increased tremendously is Rancho Cucamonga with 12.5% increase in the same two-year period.

Two demographic trends have recently gained much attention in the U.S. and the rapid growth in the Hispanic population and the projected large increase in the percentage of senior citizens, which is also evident in our county. According to the U.S. Census Bureau, Fontana is right in the forefront of one of those trends and near the very bottom

of the other one. The 2000 census revealed Fontana's percentage of Hispanics or Latinos is 57.7, the 16th highest percentage of any city of more than 100,000 in the U.S. However, at the same time Fontana's percentage of people who are 65 years and older is only 4.7, the second lowest percentage of any city of more than 100,000 in the entire country.

Homeless

Homelessness is on the rise nationally and statewide. According to the San Bernardino County 2003 Homeless Census Survey done by Applied Survey Research, the estimated point in time (daily) number of homeless residents in San Bernardino County in 2002 ranged between a minimum of 5,270 persons to as many as 8,351 persons. Survey data (2002) regarding the average length of homelessness indicates that the homeless population renews itself approximately 2.82 times during every year, or stated differently, that between 14,861 and 23,549 unduplicated San Bernardino County residents experience homelessness in a given year. This range represents between 0.8% and 1.3% of the County's total population. This percentage is comparable to current national estimates of homelessness, which range between 2.3 and 3.5 million individuals, or approximately 0.9% to 1.3% of the national population. More than two-thirds of homeless were individuals, most of which (73%) were individual adult males. 54% of the homeless population is White, 21% are Black/African American, 21% are Hispanic/Latino, 3% are Native American and 1% is Asian/Pacific Islander. Additionally, more than one-third of respondents indicted that alcohol or drug use contributed to their homelessness, and 17% indicated that alcohol and drug use was the primary cause of their homelessness. More than one in every ten respondents (12%) reported that mental health issues contributed to their becoming homeless, and 2% indicated that mental health issues were the primary cause of their homelessness.

Poverty Level

The Southern California Association of Governments' March 01 report projects a 59% increase in population in San Bernardino County by 2020. According to the census 2000, between January 1, 2002 and January 1, 2003 the County's population increased by 45,000. This trend is contributing to a jobs/housing imbalance that has been characteristic of the county for many years. Housing prices have shown a marked

increase during the past 12-month period causing more families to live together and job seekers to commute further into surrounding regions for higher paying positions. San Bernardino County ranks 27th out of 58 counties in California in poverty and 29th in child poverty. Between January 2001 and January 2002, the unemployment rate in San Bernardino County increased from 4.6 percent to 5.5 percent.

Immigrant/Seasonal Migrants

Data information regarding Migrant families is not available through the county's Department of Transitional Services, which is responsible for Cash Aid programs, and CalWORKs. According to the California State Department of Finance Legal Immigration to California Census, San Bernardino County had 3,858 legal immigrants in 1990. By the year 1998, San Bernardino County's legal immigrant residents increase 22% (4,949). In addition, according to the county's educational system in 2000-2001 there were 12,030 migrant students receiving LEP (Limited English Proficiency) services in the public elementary and secondary schools (National Center for Education Statistics). The County used to have a larger agricultural base 15 years ago. Most of the agriculture-based business is in livestock and poultry, in fact, San Bernardino County is ranked number five in the livestock, poultry and apiary and the number three in California livestock and products. The jobs created by our agriculture base businesses are year round and therefore, there are less migrant families in the county than in past years. The county offers affordable housing, which decreases the land use for agricultural purposes. San Bernardino County is used as a corridor for legal, undocumented, and migrant families due to its proximity to the Mexican border and accessibility to Los Angeles County.

Board and Care Homes

The Department of Behavioral Health works closely with 20-25 board and care homes, which includes some hotels. 15-20% of hospital discharges end up in board and care homes. Clients upon release from the hospital place themselves in these homes. Overall the Department has access to 50 beds among Augmented Board and Care (ABC)

facilities in our county. We have two ABC's primarily for dual diagnosis, one who deals with individuals with hearing impaired problems and diabetes. All ABCs deal with the persistent severely mentally ill. A major barrier that also exists in ABC facilities is the extremely limited number of bilingual staff, especially Spanish speakers. Another barrier is that ABCs are primarily located in the city of San Bernardino and not on all the regions.

DEMOGRAPHICS

GENERAL COUNTY POPULATION:

The County of San Bernardino like other counties in Southern California, experience rapid growth between 1970 and 1990. The 1970 census reported a population of 684,072 people. Between 1970 and 1990 Census, the population more than doubled (an increase of 107%), to 1.4 million people. The county has continued to grow rapidly since 1990. According to the 2000 Census, San Bernardino County's population increased to 1, 709,434 residents.

Much of the county's population growth since the 1970's is linked with the economies of Los Angeles and Orange Counties, as evidenced by the concentration of population increases in areas adjacent to or within commuting distance of these jurisdictions. Rapidly escalading housing prices during the mid-1970's and early 1980's caused and influx of residents from these areas to the more affordable housing developments in the County of San Bernardino. Population growth over the past three decades is also attributed to a marked increased in immigration from Mexico, Latin America and the Pacific Rim.

Table 12
County of San Bernardino
Population Increase: 1980-2000

Year	Population	% Increase Over Period
1980	895,016	30.8%
1990	1, 418,380	58.5%
2000	1,709,434	20.5%

General Ethnic Composition:

The racial and ethnic composition of the entire county changed significantly between the 1990 Census and the 2000 Census. The White (non-Hispanic) population, as a share of the total population, decreased from 61.0% in 1990 to 44.0% in 2000. The Hispanic population increased in terms of its percent of the total population from 26.3% to 39.28% during this same period. While the share of Blacks and Asian/Pacific Islander populations

is small, significant increases in their numbers were also reported. The number of Blacks and Asian Pacific Islanders in the county increased over the decade by 36% and 48%, respectively. The number of Native Americans decreased over this period, and their share of the overall population decreased from 0.8% to 0.57%. The shifts in the racial and ethnic composition of the population mirrored the changing demography in the region and in California as a whole. The table below provides a break down of 1990 and 2000 population figures by race and ethnicity for the entire county.

Table 13
County of San Bernardino
Population by Race and Ethnicity: 1990 and 2000

	County of San Bernardino		
	1990 Census	**2000 Census**	**% Change**
White (non-Hispanic)	864,830	752,222	-13%
Black (non-Hispanic)	110,352	150,201	36%
Hispanic (all races)	373,632	669,387	79%
Native American (non-Hispanic)	10,837	9,804	-10&
Asian & Pacific Islander (non-Hispanic)	55,710	82,541	48%
Other (non-Hispanic)	3,019	3,039	.7%
Two or More Races	*	42,240	N/A
Total Population	1,418,380	1,709,434	21%

Source: 1990 and 2000 Census data *not counted

General Population by Age

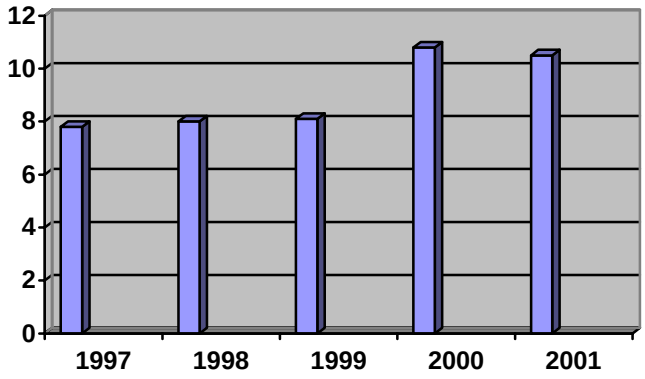
According to the Census 2000, the median age for County of San Bernardino residents was 30.3, slightly older than the median age, 27.8 years, reported in the 1990 Census. The largest segment of the population was adults ages 25-54, which comprised 42.0% of the total population. School age children, between the ages of 5 and 17 were the next largest group, constituting 24.0% of the population. The U.S. Census 2000 states that the Hispanic population is reflected in its population under age 18 and in its median age 27.8. Senior citizens, ages 65 and over, accounted for only 8.6% of the total population. Table I-2 summarizes 2000 Census data on age composition of the county.

Table 14
County of San Bernardino
Age Distribution

	2000	
Age Group	**Number**	**Percent**
Pre-school (0-4)	143,076	8.4
School (5-17)	408,971	24.0
Young Adults (18-24)	175,800	10.3
Working (25-54)	719,331	42.0
Early Retirement (55-59)	65,315	3.8
Retirement (60-64)	50,482	2.9
Senior Citizens (65+)	146,459	8.6
Total	1,709,434	100.0

Source: 2000 Census

Table 15
Children's Population Growth for Children age 0-17 years



Primary Language Spoken:

The Threshold language in the county of San Bernardino is Spanish. The identification is based in the definition provided by the state regarding Threshold language as the annual numeric identification on countywide basis, 3,000 beneficiaries or five (5%) percent of the Medi-Cal beneficiary population, which ever is lower, whose primary language is other than English, for whom information and services shall be provided in their primary language.

Bilingual Proficiency:

DBH Employees that perform bilingual translation/ interpretations involving the use of English and a second language, including American Sing Language, as part of their duties are entitled to bilingual compensation. There are three (3) levels of competency certification determined and administered by Human Resources: Level 1- Verbal skill: the use of English and a second language in a verbal contexts which may require interpretation of simple documents in the second language; Level 2- Written skill: reading and writing and speaking English and a second language; and level 3- technical skill l: reading, writing and speaking English and a second language using medical or legal terminology.

According to the 2000 Census data 34% of San Bernardino County's residents speak a language other than English. San Bernardino County has a higher population density of Spanish speakers (27.7%) than California and the United States.

Table 16
Spanish Spoken at Home

Location	Year	Percentage
United States	2001	10.8%
California	2001	26.4%
San Bernardino County	2001	27.7%

Census 2000

The specific breakdown for primary language as reported by the US census data is as follow:

Table 17
Primary Language

Language	Number	Percentage
English	1,035,292	66%
Spanish	434,445	27.7%
Other	98,988	6.3%
Total	1,568,725	100.0%

Source: U.S. Census Bureau, Census 2000

MEDI-CAL BENEFICIARIES – General:

In spite of Welfare reform, the number of medi-cal beneficiaries has remained constant throughout the years. In January 2003, there were 338,067 medi-cal beneficiaries. This number represents 20 percent of the total population of the County of San Bernardino.

Table 18

County Population	**County Medi-cal Beneficiaries**
1709,434	338,067 - 20%

Source: U.S. Census Bureau, Census 2000

Table 19
Medi-cal Beneficiaries by Age
January 2003

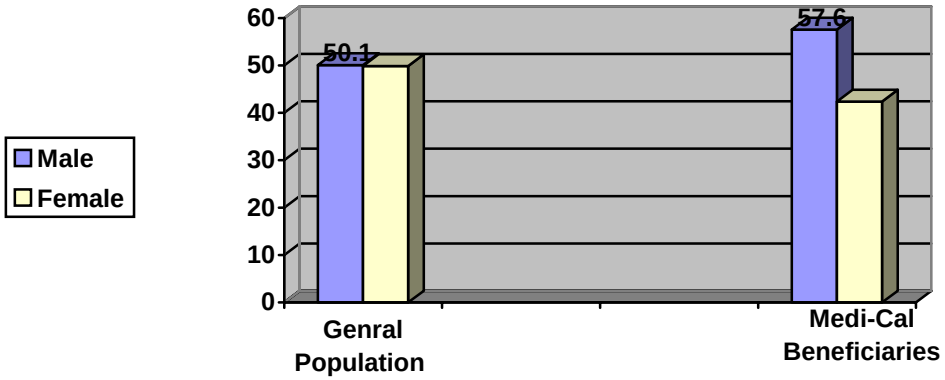
Age	Number	Percentage
0-17	180,747	53.5
18-20	15,519	4.6
21-44	80,921	23.9
45-64	31,372	9.3
65+	29,508	8.7

Source: U.S. Census Bureau, Census 2000

A further profile of Medi-cal beneficiaries indicates that 57.6 percent are females compared to 42.4 percent males. The general population is almost equal between females 50.1 percent compared to males 49.9 percent.

The population of medi-cal beneficiaries continues to be younger in age to the general population. In January 2003, more than half of medi-cal beneficiaries 53.5 percent were under 17 years of age, while only 35.5 percent of the general populations were under 19 years of age. The inverse is true with adult population, where only 37.8 percent of the medi-cal beneficiaries were between 18 and 64 years old, but 53.0 percent of the general populations were between 20 and 59 years old.

Table 20
General Population and Medi-Cal Beneficiaries by Gender
January 2003



Source: U.S. Census Bureau, Census 2000

The number of Latino/Hispanic Medi-Cal beneficiaries has grown consistently during the past four years. The growth of Latinos/Hispanics beneficiaries represents the largest component in the increase in Medi-Cal beneficiaries for the last four years. In January 2003, Latinos/Hispanics accounted for 43.6 percent of Medi-Cal beneficiaries and the threshold language for the County of San Bernardino is Spanish.

Table 21
General Population and Medi-Cal Beneficiaries
By Ethnicity
January 2003

General Population			**Medi-Cal Beneficiaries**	
Ethnicity	Number	Percentage	Number	Percentage
White	752,222	44.0	99,398	29.4
Latino/Hispanic	669,387	39.2	147,457	43.6
Africa-American	171,461	10.0	51,141	15.1
Asian	106,702	6.2	24,354	7.2
Other/Unknown	9,662	0.6	15,717	4.6
Total		1,709,434	**Total**	338,067

Source: U.S. Census Bureau, Census 2000

The Latinos/Hispanics are the fastest growing group compared to others and has the largest percentage of children between the ages of 5-18. The factors contributing to the influx may be due to agriculture (livestock) employment opportunities, affordable housing, availability of group residential facilities and the proximity to the Mexico borders.

Further review of Medi-Cal beneficiaries by region indicates that three out of four regions have a large percent of Latinos/Hispanics in their catchments area.

GENERAL COUNTY POPULATION BY REGION:

Table 22
General Ethnic Population by Regions

Ethnicity	Desert/Mountain	East	Central	West
White	177,754	179,947	42,276	245,153
Hispanic	74,552	140,997	91,374	292,486
Black	22,430	39,351	27,025	53,443
Asian	6,365	19,325	5,660	45,299
Other/Unknown	14,303	14,864	4,144	16,817
TOTAL	295,404	394,484	170,479	653,198

Source: U.S. Census Bureau, Census 2000

The Desert/Mountain region has the highest percentage of White people (60.2%) in the county. It has also the highest percentage of English Speaking residents of the county. The White population of this region has prevailing adjustment. In addition this region has the highest percentage of childhood and adolescent, anxiety and adjustment disorders which come in both through outpatient and crisis clinics.

The West Valley region has the highest percentage of Asian American residents (6.9%) in the county. It has also the second highest percentage of Spanish Speaking residents of the county. The Asian population of this region has prevailing mood disorders and the Hispanic population prevail anxiety disorder. Both ethnic groups have a high percentage of schizophrenic disorders and usually come in through crisis mode of treatment.

The East Valley region has the highest percentage of people with schizophrenia in the county. The region has 2nd highest percentage of White female English speaking. The White, female, English speaking has the highest percentage of schizophrenia and mood disorders.

The Central Valley region has the highest percentage of African American residents (15.9%) in the county. It has also the highest percentage of Spanish Speaking residents (53.6%) of the county. The African American population of this region has prevailing mood disorders and schizophrenia. The African American population prevail anxiety disorder and schizophrenia. Both ethnic groups have a high percentage of schizophrenic disorders and usually come in through crisis mode of treatment.

Table 23
General Information by Age

Age	Desert/Mountain	East	Central	West
0-19	102,226	138,768	67,006	233,299
20-24	20,994	27,320	12,675	46,613
25-44	79,627	114,797	51,072	212,834
45-59	46,215	62,520	23,759	103,860
60+	46,342	51,079	15,967	56,592
Total	295,404	394,484	170,479	653,198

Source: U.S. Census Bureau, Census 2000

The following regions have the highest concentration in the age categories:

Table 24
Regional Concentration by Age

Age	Percentage	Region
0-19	39.3%	Central
20-24	7.4%	Central
25-44	32.6%	West
45-59	15.9%	West
60+	15.7%	Desert/Mountain

Source: U.S. Census Bureau, Census 2000

Medical-Beneficiaries by Region:

Table 25
Medi-Cal Beneficiaries - Ethnicity by Region
January 2003

	Desert/Big Bear		East Valley		Central Valley		West Valley	
	#	%	#	%	#	%	#	%
White	43,281	52.0	26,119	28.1	7,293	14.2	19,406	19.3
Latino/Hispanic	22,317	26.8	36,879	39.7	27,297	53.2	58,296	57.9
African-American	10.235	12.3	18,374	19.8	11,151	21.7	9,128	9.1
Asian	3,266	3.9	7,239	7.8	3,556	6.9	9,729	9.7
Other	4,086	4.9	4,400	4.7	2,019	3.9	4,097	4.1
Total	83,185		93,011		51,316		100,656	

Source: California Department of Health Services / Medi-Cal Beneficiaries by Zip Code, Jan. 2003

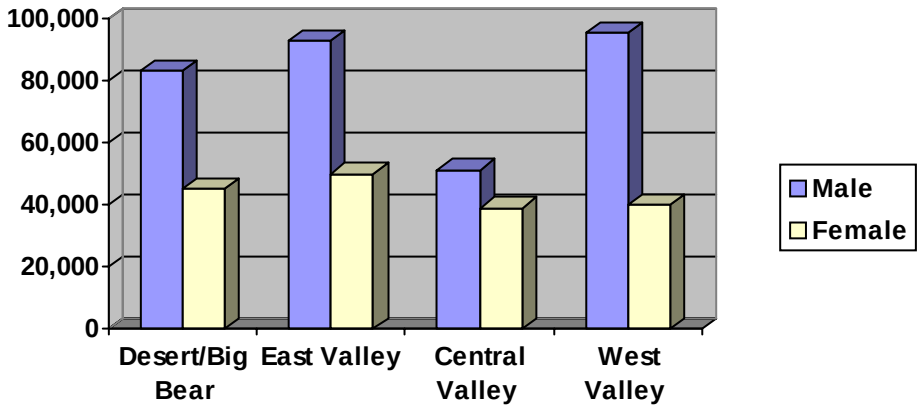
West Valley has the largest percentage 57.9; Central Valley follows with 53.2 percent and East valley with 39.7 percent. The majority of Medi-Cal beneficiaries in all four regions fall between 0 and 17 years of age and females percentages likewise are higher than males. Language, Spanish appears to be higher in the West Valley Region.

Table 26
Medi-Cal Beneficiaries - Age by Region
January 2003

	Desert/Big Bear		**East Valley**		**Central Valley**		**West Valley**	
Age	#	%	#	%	#	%	#	%
0-17	42,781	51.4	49,976	53.7	28,753	56.0	53,701	53.4
18-20	3,848	4.6	4,225	4.5	2,367	4.6	4,439	4.4
21-44	20,927	25.2	22,461	24.1	11,739	22.9	23,865	23.7
45-65	8,922	10.7	9,210	9.9	4,417	8.6	7,833	7.8
65+	67,707	8.1	7,139	7.7	4,040	7.9	10,818	10.7
Total	83,185		93,011		51,316		100,656	

Source: California Department of Health Services / Medi-Cal Beneficiaries by Zip Code, Jan. 2003

Table 27
Medi-Cal Beneficiaries - Gender by Region
January 2003



Source: California Department of Health Services / Medi-Cal Beneficiaries by Zip Code, Jan. 2003

Table 28
Medi-Cal Beneficiaries - Primary Language by Region

	Desert/Big Bear		East Valley		Central Valley		West Valley	
	#	%	#	%	#	%	#	%
English	62,173	74.7	59,043	63.5	29,911	58.3	51,152	50.8
Spanish	7,682	9.2	17,967	19.3	13,752	26.8	34,526	34.3
Asian	141	0.2	1605	1.7	394	0.8	1,594	1.6
Other	13,189	15.9	14,396	15.2	7,259	14.1	13,384	13.3

Source: California Department of Health Services / Medi-Cal Beneficiaries by Zip Code, Jan. 2003

The County of San Bernardino Department of Behavioral Health served 34,304 consumers in Fiscal year 2002-03. The total include unduplicated consumers from the department contract agencies and Fee-For-Services providers, Outpatient, and residential. Data from calendar 2002 indicates that 20,510 Medi-Cal beneficiaries received specialty mental health services in San Bernardino County.

Seasonal Migrant Workers:

Data information regarding Migrant families is not available through the county's Department of Transitional Services, which is responsible for Cash Aid programs, and CalWORKs. There is limited information on seasonal migrant workers.

According to the California State Department of Finance Legal Immigration to California Census, San Bernardino County had 3,858 legal immigrants in 1990. By the year 1998, San Bernardino County's legal immigrant residents increase 22% (4,949). In addition according to the county's educational system, there are 12,030 migrant students receiving LEP (Limited English Proficiency) services in the public elementary and secondary schools. The County used to have a larger agricultural base 15 years ago. Most of the agriculture-based business is in livestock and poultry, in fact, San Bernardino County is ranked number five in the livestock, poultry and apiary and the number three in California livestock and products. The jobs created by livestock (agriculture) has become year round work instead of the seasonal type of employment.

UTILIZATION OF MEDI-CAL BENEFICIARIES

Mental Health Services:

Medi-Cal beneficiaries with specialty mental health services in San Bernardino County during calendar years 2002 had a total of 20,510 consumers receiving services. Forty-eight percent of the total were Caucasian, 25.8 percentage were Latino/Hispanic and 19.9 percent were African-American. Thirty-nine percentage-receiving services were between the ages of 21-44 with record highest 0-17. Females outnumbered males 54.0% to 45.9%. Mood disorders were the primary diagnosis (44.9%) compared to 20.5% of Schizophrenia/Psychotic disorders. Primary Language was English, 89.5%.

Table 29
Ethnicity

	Number	Percentage
White	9,911	48.3
Latino/Hispanic	5,301	25.8
Africa-American	4,077	19.9
Asian	470	2.3
Other/Unknown	741	3.7
Total	**20,510**	**100.00%**

Table 30
Age Group

	Number	Percentage
0-17	7,098	34.6
18-20	732	3.6
21-44	8,026	39.1
45-64	4,281	20.9
65+	373	1.8
Total	**25,510**	**100.00%**

Table 31
Sex

	Number	Percentage
Female	11,085	54.0
Male	9,408	45.9
Unknown	17	0.1
Total	**20,510**	**100.00%**

Table 32
Primary Language

	Number	Percentage
English	18,351	89.5
Spanish	743	3.6
Asian	282	1.4
Other/Unknown	1,134	5.5
Total	**20,510**	**100.00%**

Table 33
Primary Diagnosis

	Number	Percentage
Mood Disorders	9,219	44.9
Schizophrenia/Psychotic Disorder	4,211	20.5
Childhood & Adolescent	3,563	17.4
Anxiety Disorders	1,603	7.8
Adjustment Disorder	1,199	5.8
Other Diagnosis	715	3.5
Total	**20,510**	**100.00%**

Medi-Cal Beneficiaries with Outpatient Specialty Mental Health Services in San Bernardino County during calendar year 2002:

Table 34
Gender

	Number	Percentage
Female	10,964	54.0
Male	9,311	45.9
Unknown	17	0.1
Total	**20,292**	**100.00**

Table 35

Age Group

	Number	Percentage
0-17	7,024	34.6
18-20	718	3.5
21-44	7,929	39.1
45-64	4,253	21.0
65+	366	1.8
Total	**20,292**	**100.00%**

Table 36
Primary Language

	Number	Percentage
English	18,162	89.5
Spanish	729	3.6
Asian	280	1.4
Other/Unknown	1,121	5.5
Total	**20,292**	**100.00%**

Table 37
Primary Diagnosis

	Number	Percentage
Mood Disorders	9,099	44.8
Schizophrenia/Psychotic Disorder	4,171	20.6
Childhood &Adolescent Disorders	3,543	17.5
Anxiety Disorders	1,587	7.8
Adjustment Disorders	1,186	5.8
Other Diagnosis	706	3.5
Total	**20,292**	**100.00%**

Caucasians utilized outpatient services more than other groups (48.4%) compared to Latino/Hispanics 25.8% and 19.9% African-American. Thirty-nine percentage of total were between 21-44 years of age, with 0-17 a record high. Primary diagnosis was mood disorders with 44.8%.

Medi-Cal Beneficiaries with Day Treatment/Residential Specialty Mental Health Services in San Bernardino County during calendar year 2002:

Table 38
Ethnicity

	Number	Percentage
White	456	51.8
Latino/Hispanic	178	20.2
Black	191	21.7
Asian	17	1.9
Other/Unknown	39	4.4
Total	**881**	**100.00%**

Table 39
Age Group

	Number	Percentage
0-17	93	10.6
18-20	48	5.4
21-44	487	55.3
45-64	243	27.6
65+	10	1.1
Total	**881**	**100.00%**

Table 40
Sex

	Number	Percentage
Female	409	46.4
Male	472	53.6
Unknown	0	0.0
Total	**881**	**100.00%**

Table 41

Primary Language

	Number	Percentage
English	802	91.0
Spanish	9	1.0
Asian	3	0.3
Other/Unknown	67	7.6
Total	**81**	**100.00%**

Table 42
Primary Diagnosis

	Numbered	Percentage
Mood Disorders	296	33.6
Schizophrenia/Psychotic Disorder	517	58.7
Childhood & Adolescent Disorder	26	3.0
Anxiety Disorder	15	1.7
Adjustment Disorder	2	0.2
Other Diagnosis	25	2.8
Total	**881**	**100.00%**

Fifty-one point eight percent of day treatment services were delivered to Caucasians. African-Americans had 21.7%, slightly above Latino/Hispanics with 20.2%. Primary diagnosis for day treatment services was Schizophrenia/Psychotic disorder 58.7%.

Medical Beneficiaries with Crisis Specialty Mental Health Services in San Bernardino County during calendar year 2002:

Table 43
Ethnicity

	Number	Percentage
White	2,415	50.3
Latino/Hispanic	1,123	23.4
African-American	1,017	21.2
Asian	79	1.6
Other/Unknown	163	3.4
Total	**4,797**	**100.00%**

Table 44

Age Group

	Number	Percentage
0-17	1,099	22.9
18-20	252	5.3
21-44	2,422	50.5
45-64	951	19.8
65+	73	1.5
Total	**4,797**	**100.00%**

Table 45
Sex

	Number	Percentage
Female	2,623	54.7
Male	2,169	45.2
Unknown	5	0.1
Total	**4,797**	**100.00%**

Table 46
Primary Language

	Number	Percentage
English	4,451	92.8
Spanish	104	2.2
Asian	26	0.5
Other/Unknown	216	4.5
Total	**4,797**	**100.00%**

Table 47
Primary Diagnosis

	Number	Percentage
Mood Disorders	2,483	51.8
Schizophrenic/Psychotic Disorder	1,466	30.6
Childhood & Adolescent Disorders	312	6.5
Anxiety Disorder	187	3.9
Adjustment Disorder	137	2.9
Other Diagnosis	212	4.4
Total	**4,797**	**100.00%**

Majority of services were rendered to Caucasians 50.3% compared to Latino/Hispanics 23.4% and Africa-Americans slightly behind with 21.2%. Fifty-five percentages of individuals receiving crisis services were between the ages of 21-44.

Medi-Cal Beneficiaries with Inpatient Specialty Mental Health Services

in San Bernardino County Calendar year 2002:

Table 48
Ethnicity

	Number	Percentage
White	1,234	52.4
Latino/Hispanic	563	23.9
African-American	436	18.5
Asian	40	1.7
Other/Unknown	83	3.5
Total	**2,356**	**100.00%**

Table 49

Age Group

	Number	Percentage
0-17	506	21.5
18-20	159	6.7
21-44	1,209	51.3
45-64	463	19.6
65+	20	0.8
Total	**2,356**	**100.00%**

Table 50
Sex

	Number	Percentage
Female	1,252	53.1
Male	1,098	46.6
Unknown	6	0.3
Total	**2,356**	**100.00%**

Table 51
Primary Language

	Number	Percentage
English	2,231	94.7
Spanish	46	2.0
Asian	12	0.5
Other/Unknown	67	2.8
Total	**2,356**	**100.00%**

Table 52
Primary Diagnosis

	Number	Percentage
Mood Disorders	1,231	52.5
Schizophrenic/Psychotic Disorders	881	37.4
Childhood & Adolescent Disorders	103	4.4
Anxiety Disorders	35	1.5
Adjustment Disorders	24	1.0
Other Diagnosis	82	3.5
Total	**2,356**	**100.00%**

Caucasians surprised utilization of their services over any other group. Latinos/Hispanics were a distant second with 23.9% and African-American with 18.5%.

Mental Health Services by Regions:

Medi-Cal beneficiaries with specialty mental health services in San Bernardino County during calendar year 2002

The department is divided into four regions: Desert/Big Bear, East Valley, Central Valley and West Valley.

Caucasians continue to out number any other group in recovery specialty mental health services in three regions. Latino/Hispanics out numbered Caucasians by 6.4 percent in Central Valley region. Eighteen-twenty was the dominant age in three regions except Central Valley. A primary diagnosis was mood disorders in all four regions (see attachment 3).

Medi-Cal beneficiaries with outpatient specialty mental health services in San Bernardino County during calendar year 2002

Hispanics were slightly higher than Caucasians in Central Valley by 6.4 percent. Caucasians outnumbered every group in three regions. The majority of services were rendered to those 21-44 years of age. Mood disorders were primary in all regions (see attachment 4).

Medi-Cal beneficiaries with crisis specialty mental health services in San Bernardino County during calendar year 2002

Crisis services were delivered to more Caucasians than any other group in four regions. Crisis appears to be higher in ages 0-17. Mood disorders was highest among diagnosed (see attachment 5).

Medi-Cal beneficiaries with day treatment/residential specialty mental health services in San Bernardino County during calendar year 2002

Caucasians received more day treatment services than any other group. Ages 21-44 was the highest Schizophrenia/Psychotic disorders were the highest (see attachment 6).

Medi-Cal beneficiaries with inpatient specialty mental health services in San Bernardino County during calendar year 2002

Again, data indicates Caucasians were the primary group receiving inpatient services along with ages 21-44. Mood disorders again were the highest among other diagnosis (see attachment 7).

Analysis:

1. Overall access and penetration rates are low for Latinos/Hispanics in all level of services.
2. English is the primary language. The number of Spanish speaking consumers is extremely low. Our data collection may not be asking consumers for their language of preference.
3. Mood disorders are the primary diagnosis among consumers in all types of mental health service. This information will be useful in planning for regional services.
4. Outreach strategies need to be developed and tailored to regional demographics in order to increase access/penetration rates for diverse populations especially Latino/Hispanics. The Cultural Competency Committee can play a big part in assisting regions with outreach strategies. Medi-Cal beneficiaries with inpatient specialty mental health services in San Bernardino County during calendar year 2002, by region.
5. Education Primary Prevention that includes an anti-stigma campaign.

Measurable Objectives:

The County of San Bernardino Department of Behavioral Health has the same barriers presented to them as the rest of the California County's in providing quality mental health services to ethnic populations. Our penetration and retention rates demonstrate the disparities in access to ethnic populations, especially the Latinos. Therefore, the need for culturally and linguistically competent services is needed in order to reach this population. DBHs first objective is to continue with the Latino Access Study required by State Department of Mental Health and to complete it by June 2005. This study will provide the county with vital information in addressing and outreaching to this population.

Although, Spanish is the county's threshold language, it was discovered that the number of Spanish speaking clients is extremely low according to the data collected by our system. This discrepancy suggests that we are not capturing the data or that we are not asking the correct information from our clients. The second objective is to have the San Bernardino County Department of Behavioral Health continue working with Medi Tech. technologies in developing a new system that will allow us to collect and retract data needed for analysis and comparisons. This project has several steps and will take a couple of years to complete.

The third objective is to address primary diagnosis. Mood disorders is the primary diagnosis across ethnic groups, but in order to identify the correct approach in working with these populations, the county needs to find alternatives strategies.

The final objective is to develop outreach strategies by regions. Strategies will be developed and tailored to each region. Outreach will be done in the communities with a high concentration of ethnic minorities. The outreach will be specifically design to let clients know of our services, provide education and introduce the anti-stigma campaign. The following is a list of activities that will be done at least once yearly for outreach purpose:

- Establish Client Councils
- Client Group Facilitation Training to grassroots organizations, churches and other community groups.
- Focus Groups
- Education/Prevention Community Forum
- Spanish Speaking Radio Program

Population Trends

Medi-cal Beneficiaries population trends in the County of San Bernardino indicates that the number of Latinos have increase from 2002 to 2003 by 4%. Latinos have the highest population in the 5-21 age bracket indicating the need for services to children. Our department has addressed this issue by recently changing our focus to serve more children. Although our threshold language is Spanish, we have a high concentration of Vietnamese clients in the West Valley; therefore, we are trying to allocate resources to meet the need.

According to the welfare information since the implementation of CalWORKs their numbers have decreased, but in the Latino population the numbers have increase consistently indicating that we need to emphasize in addressing this population.

San Bernardino County used to be known as a place with employment in agriculture, but in the past decade San Bernardino County became an industrialized county. Home builders eliminating agriculture land and built homes and shopping centers. The agriculture jobs that are left in the county are in livestock and commodities. This type of employment is usually year long reducing the number of seasonal workers and/or migrant workers.

Part II:
Organizational and Service
Provider Assessment Update

S TAFF RESOURCES

The San Bernardino County Department of Behavioral Health had about 815 employees in June 2003. The 815 do not include the number of F.T.E's in the department due to recent budget crisis; the department's workforce has been impacted by lay-offs, bumping by other departments and attrition. The departments Human Resources unit is in the process of updating current workforce and our ability to provide cultural and linguistic services to residents of this County.

Fifty percent of the employees are Caucasian, compared to only forty-four percent of the general population. 39 percent of the population of San Bernardino is Latino/Hispanic. The departments Latino/Hispanic workforce represents 25 percent. Conversely, while only 8 percent of the workforce is Asian American, 17 percent of the mental health staff is African-American.

11 percent Latino/Hispanic, 8 percent Caucasian and 5 percent African-American represent supportive staff such as clerical. Further review indicates that direct services are provided by 31 percent Caucasian, 8 percent Latino/Hispanic and 7 percent African-American.

Table 53
DBH Current Staff Composition by Ethnicity

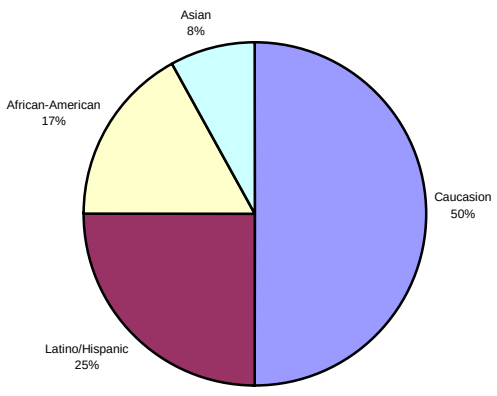
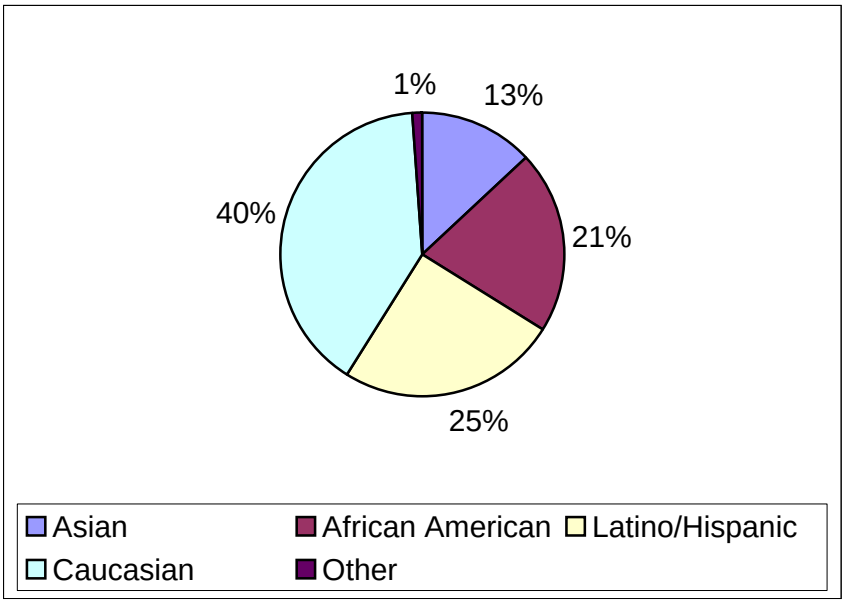


Table 54
Contract Agencies Current Composition by Ethnicity



Source: DBH survey to contract providers 2003

Forty percent of the employees are Caucasian, twenty-five percent are Latino/Hispanics, twenty-one are African American, thirteen percent are Asian, and one percentage is other.

Table 55
Overall Composition Of County Mental Health Staff –
Ethnicity By Function

	Administration		Direct Services		Support Services		Total
	Number/Percentage		Number/Percentage		Number/Percentage		
Caucasian	87	11	150	31	71	8.7	50%
African American	34	4	60	7	49	6	17%
Latino/Hispanic	43	5	67	8	97	11.9	25%
Asian	7	.09	50	6	5	.06	.08%
African-American	3	.03	4	1.5	1	.01	

Source: HR report 2003

While 25 percent of total employees are Latino/Hispanic, 8 percent are providing direct services. There is a need to further identify percentages per classification for

Latinos/Hispanics in Mental Health. (i.e. Mental Health Specialist, Social Worker or Clinical Therapists I or II, etc.).

Table 56
Overall Composition Of Mental Health Staff
Contract Providers Ethnicity By Function

Total: 288	**Caucasian**		**Latino/ Hispanic**		**African American**		**Asian American**		**Other**		**Total**	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Administration/ Management 26	**22**	**84%**	**2**	**.08%**	**2**	**.08%**	**0**	**0**	**0**	**0**		**100**
Direct Services 216	**99**	**45.8%**	**43**	**19.9%**	**62**	**28.7%**	**9**	**4.2%**	**3**	**1.4%**		**100**
Support Services 27	**18**	**67%**	**6**	**22%**	**3**	**11%**	**0**	**0**	**0**	**0**		**100**
Volunteers/Consumers 19	**11**	**57.9%**	**4**	**21.1%**	**1**	**5.2%**	**3**	**15.8%**	**0**	**0**		**100**

Table 57
Overall Composition of County Mental Health Providers
Bilingual Staff by Function and Language

Total: 521	**English**	**%**	**Spanish**	**%**	**Other**	**%**
Administration /Management 53	**44**	**83%**	**8**	**15%**	**1**	**2%**
Direct Services 341	**252**	**74%**	**54**	**16%**	**35**	**10%**
Support Services 99	**40**	**41%**	**59**	**59%**	**0**	**0**
Volunteers/ Consumers 28	**24**	**86%**	**3**	**11%**	**1**	**3%**

Table 58
Overall Contract Providers
Bilingual Staff by Function and Language

Total: 570	English	%	Spanish	%	Other	%
Administration /Management 51	41	80%	3	6%	7	14%
Direct Services 456	386	86%	26	6%	34	8%
Support Services 41	22	54%	8	20%	11	26%
Volunteers/ Consumers 22	16	73%	2	9%	4	18%

Table 59
Overall Composition of Department of Behavioral Health
Staff Proficient in Reading and/or writing in a language other than English

Total: 125	Number	%	Spanish	American Sign Language	Other	Verbal	Written	Technical
Administration /Management	8	6%	8	0	0	3	0	5
Direct Services	50	40%	50	4	7	21	4	24
Support Services	67	54%	67	0	0	38	11	19

Table 60
Overall Composition of Contract Providers
Staff Proficiency in Writing /Reading

Total: 570	Spanish		English		Other		Verbal		Written		Technical	
	N	%	N	%	N	%	N	%	N	%	N	%
Administration/ Management 51	3	6%	41	80%	7	14%	3	100%	0	0	0	0
Direct Services 456	26	6%	386	86%	34	8%	53	88%	6	10%	1	2%
Support Services 41	8	20%	22	54%	11	26%	12	63%	4	21%	3	16%
Volunteers/Consumers 22	2	9%	16	73%	4	18%	4	67%	2	33%	0	0

Table 61
Location of Department of Behavioral Health Mental Health staff
Ethnicity by function
East/Central Valley

Total: 293	**Gender**		**Caucasian**		**Latino/ Hispanic**		**African American**		**Asian American**		**Other**	
	M	F	N	%	N	%	N	%	N	%	N	%
Administration/ Management 36	13	23	22	61%	6	16.8%	2	5.4%	6	16.8%	0	0
Direct Services 190	51	139	105	55.3%	22	11.6%	32	16.8%	25	13.2%	6	3.1%
Support Services 49	2	47	11	22.5%	26	53%	12	24.5%	0		0	0
Volunteers/Consumers 18	5	13	4	22.2%	5	27.8%	5	27.8%	4	22.2%	0	0

Table 62
Location of Contract Service Providers Mental Health Staff
Ethnicity by function
East/Central Valley Region

Total: 469	**Gender**		**Caucasian**		**Latino/ Hispanic**		**African American**		**Asian American**		**Other**	
	M	F	N	%	N	%	N	%	N	%	N	%
Administration/ Management 41	13	28	24	58%	9	22%	5	12.5%	3	7.5%	0	0
Direct Services 387	130	257	206	53%	86	22%	34	9%	56	14%	5	2%
Support Services 23	0	23	11	48%	8	35%	3	13%	1	4%	0	0
Volunteers/Consumers 18	4	14	10	55%	3	17%	1	6%	4	22%	0	0

Table 63
Location Department of Behavioral Health
Ethnicity by Function
West Valley Region

Total: 293	**Gender**		**Caucasian**		**Latino/ Hispanic**		**African American**		**Asian American**		**Other**	
	M	F	N	%	N	%	N	%	N	%	N	%
Administration/ Management 5	4	1	3	60%	2	40%	0		0		0	0
Direct Services 82	33	49	37	46.3%	21	25.6%	7	8.5%	17	20.6%	0	0
Support Services 27	0	27	10	37%	13	48%	4	15%	0		0	0
Volunteers/Consumers 7	1	6	4	57%	1	15%	0		2	28%	0	0

Table 64
Location Contract Services Providers
Ethnicity by function
West Valley Region

Total: 56	**Gender**		**Caucasian**		**Latino/ Hispanic**		**African American**		**Asian American**		**Other**	
	M	**F**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Administration/ Management 3	**2**	**1**	**3**	**100%**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Direct Services 40	**5**	**35**	**18**	**45%**	**17**	**43%**	**2**	**5%**	**3**	**7%**	**0**	**0**
Support Services 12	**1**	**11**	**10**	**83%**	**2**	**17%**	**0**	**0**	**0**	**0**	**0**	**0**
Volunteers/Consumers 1	**0**	**1**	**0**	**0**	**1**	**100%**	**0**	**0**	**0**	**0**	**0**	**0**

Table 65
Location Department of Behavioral Health
Ethnicity by Function
Desert Mountain Region

Total: 107	**Gender**		**Caucasian**		**Latino/ Hispanic**		**African American**		**Asian American**		**Other**	
	M	F	N	%	N	%	N	%	N	%	N	%
Administration/ Management 12	6	6	7	58%	4	34%	1	8%	0	0	0	0
Direct Services 69	30	39	47	68%	8	11.4%	6	8.8%	6	8.8%	2	3%
Support Services 23	1	22	12	52%	9	39%	2	9%	0	0	0	0
Volunteers/Consumers 3	0	3	2	67%	1	33%	0	0	0	0	0	0

Table 66
Location Contract Services Providers
Ethnicity by function
Desert Mountain Region

Total: 45	**Gender**		**Caucasian**		**Latino/ Hispanic**		**African American**		**Asian American**		**Other**	
	M	**F**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Administration/ Management 7	**2**	**5**	**7**	**100%**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Direct Services 29	**13**	**16**	**24**	**83%**	**2**	**7%**	**2**	**7%**	**1**	**3%**	**0**	**0**
Support Services 6	**1**	**5**	**5**	**83%**	**1**	**17%**	**0**	**0**	**0**	**0**	**0**	**0**
Volunteers/Consumers 3	**1**	**2**	**3**	**100%**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Table 67
Location Department of Behavioral Health
Bilingual Staff by Function and Language
East/Central Valley Region

Total: 293	English	%	Spanish	%	Other	%
Administration /Management 36	28	78%	6	17%	2	5%
Direct Services 190	147	77%	22	12%	21	11%
Support Services 49	17	35%	31	63%	1	2%
Volunteers/ Consumers 18	15	83%	2	12%	1	5%

Table 68
Location Contract Service Providers
Bilingual Staff by Function and Language
East/Central Region

Total: 459	English	%	Spanish	%	Other	%
Administration /Management 41	32	78%	2	5%	7	17%
Direct Services 387	341	88%	15	4%	31	8%
Support Services 13	7	54%	5	38%	1	8%
Volunteers/ Consumers 18	13	72%	2	11%	3	17%

Table 69
Location Department of Behavioral Health
Bilingual Staff by Function and Language
West Valley Region

Total: 121	English	%	Spanish	%	Other	%
Administration /Management 5	3	60%	2	40%	0	0
Direct Services 82	57	71%	17	21%	8	8%
Support Services 27	13	48%	14	52%	0	0
Volunteers/ Consumers 7	6	85%	1	15%	0	100%

Table 70
Location Contract Service Providers
Bilingual Staff by Function and Language
West Valley Region

Total: 56	English	%	Spanish	%	Other	%
Administration /Management 3	2	67%	1	33%	0	0
Direct Services 40	18	45%	19	47%	3	8%
Support Services 12	10	84%	2	16%	0	0
Volunteers/ Consumers 1	0		0	0	1	100%

Table 71
Location Department of Behavioral Health
Bilingual Staff by Function and Language
Desert Mountain Region

Total: 107	English	%	Spanish	%	Other	%
Administration /Management 12	9	75%	3	25%	0	0
Direct Services 69	51	74%	4	6%	14	20%
Support Services 23	16	70%	7	30%	0	0
Volunteers/ Consumers 3	2	67%	1	33%	0	0

Table 72
Location Contract Service Providers
Bilingual Staff by Function and Language
Desert Mountain Region

Total: 45	English	%	Spanish	%	Other	%
Administration /Management 7	7	100%	0	0	0	0
Direct Services 29	26	89%	2	7.5%	1	3.5%
Support Services 6	5	83%	1	17%	0	0
Volunteers/ Consumers 3	3	100%	0	0	0	0

Table 73
Location Department of Behavioral Health
Staff Proficiency in Writing /Reading
East /Central Valley Region

Total: 90	Spanish				Other			
	N	Verbal	Written	Technical	N	Verbal	Written	Technical
Administration/ Management 8	6	3	1	2	2	2	0	0
Direct Services 44	22	8	3	11	22	16	6	0
Support Services 34	31	17	3	10	1	1	0	0
Volunteers/Consumers 3	2	2	2	0	1	1	0	0

Table 74
Location of Contract Services Providers
Staff Proficiency in Writing /Reading
East/Central Valley Region

Total: 66	Spanish				Other			
	N	Verbal	Written	Technical	N	Verbal	Written	Technical
Administration/ Management 9	2	2	0	0	7	5	2	0
Direct Services 46	15	10	3	2	31	15	10	5
Support Services 6	5	3	1	1	1	1	0	0
Volunteers/Consumers 5	2	2	0	0	3	3	0	0

Table 75
Location Department of Behavioral Health
Staff Proficiency in Writing /Reading
West Valley Region

Total: 43	Spanish				Other			
	N	Verbal	Written	Technical	N	Verbal	Written	Technical
Administration/ Management 2	0	0	0	2	0	0	0	0
Direct Services 25	17	4	1	4	8	4	2	2
Support Services 14	14	4	4	6	0	0	0	0
Volunteers/Consumers 2	1	1	0	0	0	0	0	0

Table 76
Location Contract Services Providers
Staff Proficiency in Writing /Reading
West Valley Region

Total: 26	Spanish				Other			
	N	Verbal	Written	Technical	N	Verbal	Written	Technical
Administration/ Management 1	1	1	0	0	0	0	0	0
Direct Services 22	19	15	2	2	3	3	0	0
Support Services 2	2	2	0	0	0	0	0	0
Volunteers/Consumers 1	0	0	0	0	1	1	0	0

Table 77
Location Department of Behavioral Health
Staff Proficiency in Writing /Reading
Desert Mountain Region

Total: 29	Spanish				Other			
	N	Verbal	Written	Technical	N	Verbal	Written	Technical
Administration/ Management 3	3	3	0	0	0	0	0	0
Direct Services 18	4	2	2	0	14	10	2	2
Support Services 7	7	6	1	0	0	0	0	0
Volunteers/Consumers 1	1	1	0	0	0	0	0	0

Table 78
Location Contract Services Providers
Staff Proficiency in Writing /Reading
Desert Mountain Region

Total: 4	Spanish				Other			
	N	Verbal	Written	Technical	N	Verbal	Written	Technical
Administration/ Management 0	0	0	0	0	0	0	0	0
Direct Services 3	2	2	0	0	1	1	0	0
Support Services 1	1	1	0	0	0	0	0	0
Volunteers/Consumers 0	0	0	0	0	0	0	0	0

Department of Behavioral Health and Contract Providers

ANALYSIS

Comparing contract provider's workforce percentages to the Department of Behavioral Health indicate that bilingual resources for Spanish-speaking clients are insufficient to meet language needs. For example, direct services staff represents 27 percentages and twenty percentages for support services. These figures are confirmed in table 3-4

The Department staff proficiency in reading and/ or writing in a language other than English among direct service providers are in the verbal category. Verbal skills are the highest level for direct service bilingual staff.

Contract Service Providers by location indicates low percentages of Latinos/Hispanics staff among all three-department regions. Current staffing is not sufficient to meet Medi-Cal beneficiaries language needs in all three regions. This problem is also confirmed in all Outpatient sites through the county.

Several problems are evident. There is insufficient bilingual staff in the department as well with contract providers.

The highest proficiency percentages are in the category of verbal skills. Insufficient percentages in written or technical category impact our ability to translate required information into Spanish.

It is the goal of the San Bernardino County Department of Behavioral Health to maximize existing workforce, contract agencies and Fee-For-Services procedures in their ability to provide the services culturally and linguistically to the residents of this county. In order to accomplish this goal, several barriers and objectives have been identified:

Barriers / Objectives

1. ***Barrier:***

   Some regions are over staffed with bilingual personnel

   Objective:

   Reassignment of staff in order to meet the linguistic demand for service

2. ***Barrier:***

   Some staff receiving bilingual pay are not listed in the department resource list.

   Objective:

   Update resource list quarterly. Contract providers information will be included.

3. ***Barrier:***

   Bilingual clerical staff are not used consistently for interpretation services.

   Objective:

   Develop a policy that will outline the usage of bilingual clerical staff for interpretation.

4. ***Barrier:***

   New Bilingual staff have not been trained for interpretation Services

   Objective:

   Provide interpretation Training for all new staff.

5. ***Barrier:***

   Insufficient bilingual staff

   Objective:

   Develop recruitment and retention strategies for the department and contract providers

Part III:
Training in
Cultural Competence

TRAINING IN CULTURAL COMPETENCE

The County of San Bernardino Department of Behavioral health recognizes the importance of training to increase DBH and contract agencies staff knowledge and skills in provision of behavioral services to the diverse populations. In order to facilitate training the department provides the following venues:

A) DBH Sponsor training coordinated through the Training Unit.
B) County Agencies
C) State
D) Other community and mental health organizations

Employees may attend trainings on county time and registration fees and other training expenses may be cover by the employee's educational funds.

The Department of Behavioral Health's Training Unit is dedicated to staff development. In August 1999, the director approved a policy regarding mandatory Cultural Diversity Training. In order to implement a Cultural Diversity Training program the Cultural Competence Committee created the Cultural Competence Training subcommittee for the selection and coordination of cultural competence trainings.

The Cultural Competence Training Subcommittee developed a training coordinator guidelines to review training applications and outlines in order to ensure the quality of training regarding relevance of the topic, inclusion of cultural competence issues, and issues of diversity appropriate for the population served in our clinics. The Training Unit

is also making sure that all trainings meet the requirements for Continuing Education Units according to the Licensing Boards.

The following is the list of all trainings provided by the Department's Training Unit during the year 2002-2003:

Table 80

DBH 2002 – 2003
MHP Provided Training:

List of trainings by functions:

A) **Administration Management (clinic supervisors, Program Managers, Deputy Directors)**
B) **Direct Services: MHP's staff**
C) **Direct Services: Contractors**
D) **Support services (includes clerical staff, staff analysts, data entry)**
E) **Interpreters.**
F) **Other: General Public, consumers, community agencies**
G) **Unknown**

DATE	Training Description	Attendees by Function	# Of Attendees
01/02/02	**Treatment Issues & Cultural Consideration in working with Native American Population.**	A **B** **C** **D**	**9** **45** **12** **3**
01/24/02	**Mandatory Confidentiality Training for Clerical and support staff.**	A **B** **D**	**6** **3** **12**
02/20/02	**Chart Documentation. Presenter: Dr. Ebbe,**	A **B** **D**	**2** **18** **4**
02/28/02	**DSM IV Presenter:Christopher Ebbe, Ph.D**	A **B**	**1** **8**
03/20/02	**Gay & Lesbian Diversity Issues Presenter: Peter Nordi**	A **B** **C** **D**	**15** **43** **18** **7**
03/12/02	**Principles for Determination of Length & Type of Treatment. Presenter: Dr. Ebbe**	A **B** **C**	**7** **23** **5**

03/29/02	**Case Management. for Program Managers & Supervisors Presenter: Dr. Ralph Ortiz**	A **B**	**4** **16**
4/2/02	**Clinical Supervision Presenter: Phyllis Rattely**	A **B** **C**	**45** **12** **3**
4/24/02	**Int. Spirituality & Psychology. Presenter: Al Dueck**	A **B** **C** **D**	**14** **42** **6** **4**
5/17/02	**Brief Solution Orientation and Family Focus Presenter: Bill O'Hanlon Hours:**	A **B** **C** **D**	**13** **42** **11** **7**
5/28/02	**Law & Ethics Update Presenter: Dr. Ebbe**	A **B** **C** **D**	**12** **42** **12** **4**
6/21/02	**Psychotherapy with Gay and Lesbians, and Bi-sexual. Presenter: J.M, Evosevich**	A **B** **C** **D**	**7** **25** **3** **6**
6/25/02 Sess. 6	**Solution Focused Brief Therapy Presenter: Marshal Jung**	A **B**	**3** **12**
5/21/02 Sess. 5	**Solution Focused Brief Therapy Presenter: Marshal Jung**	A **B**	**3** **12**
4/23/02 Sess.4	**Solution Focused Brief Therapy. Presenter: Marshal Jung**	A **B**	**3** **12**
3/19/02 Sess. 3	**Solution Focused Brief Therapy Presenter: Marshal Jung Hours**	A **B**	**3** **12**
7/12/02	**Clinical Crisis Intervention Presenter: Rose Monteiro**	A **B** **C** **D**	**3** **21** **4** **3**
7/25/02	**DSM-IV Presenter: Dr. Ebbe**	A **B**	**6** **14**
07/30/02	**DBH-Chart Documentation Presenter: Dr. Ebbe**	A **B** **C** **D** E	**2** **15** **2** **2**

07/25/02	**Work Performance Evaluations.** **Presenter: Janet Serros**	A	**25**
07/31/02	**1st Annual Part** **Presenter: Constance Burgess**	No data available	**79**
8/29/02	**Supervising consumers and Care Provider.** **Presenter: Dr. Amenson**	A **B** **C** **D**	**13** **12** **2** **3**
9/10/02	**Power & Heal.** **of play Therapy.** **Presenter: Debra Gordon**	A **B** **C** **D**	**7** **29** **3** **1**
9/23/02	**Orientation to** **Mental Health Recovery vision/** **The consumer perspective.** **Presenter: Amy Long** **Hours: 8**	A **B** **C** **D**	**57** **241** **14** **45**
9/26/02	**Family Violence. & Therapy Issues.** **Presenter: Geraldine Butts**	A **B** **C** **D** **E**	**11** **49** **23** **5** **3**
10/16/02	**DSM IV (Basic)** **Presenter: Dr. Ebbe**	A **B** **C** **D**	**4** **56** **4** **1**
10/18/02	**Impact of Mental** **Illness On a Family.** **Presenter: marshal Jung**	A **B** **C** **D**	**9** **16** **2** **3**
10/23/02	**Engaging clients in the Recovery** **Presenter: Kim Kmetz**	A **B** **C** **D**	**26** **112** **7** **18**
10/16/02	**DSM IV (Basic)** **Presenter: Dr. Ebbe**	A **B**	**6** **58**
10/18/02	**Impact of Mental Illness on Family.** **Presenter: Marshal Jung**	A **B** **C**	**9** **20** **1**
10/22-25/03	**Finding Your** **Core Gifts/ Recovery vision implementation.** **Presenter: Bruce Anderson**	A **B** **C** **D**	**6** **23** **1** **2**

10/23/02	**Introduction to Case Management.** **Presenter: Marshal Jung**	A **B** **C** **D**	**5** **32** **3** **5**
10/31/02	**Clinical Supervision.** **Presenter: Dr. Ebbe**	A **B**	**35** **2**
11/12/02	**Interacting with Consumer Programs** **Presenter: Chris Amenson**	A **B** **C** **D** E **F** **G**	**15** **53** **4** **9**
11/21/02	**Interacting with Consumer Programs** **Presenter: Chris Amenson**	A **B** **C** **D**	**21** **134** **13** **35**
11/12/02	**Advanced Case Management.** **Presenter: Marshall Jung** **Hours**	A **B**	**12** **8**
2/4/03	**Law & Ethics** **Presenter: Marshal Jung** **Hours:**	A **B**	**35** **51**
2/20/03	**Rorschach In** **Presenter: Dr. Viglione**	A **B**	**3** **32**
2/14/03	**Work Performance Evaluation and Documentation.** **Presenter: Janet Serros**	A	**15**
3/6/03	**Confidentiality. What clerical staff needs to know.** **Presenter: Lee Russell**	A **D**	**4** **18**
3/6/03	**Video Conf. Ed. Disability. Teleconference**	(No data available)	**(no data available)**
3/12/03	**Chart Documentation.** **Presenter: Dr. Ebbe** **Hours**	A **B**	**3** **12**
3/28/03	**Diagnosing & Identifying** Dual Disorders. **Presenter: Tina Gordon**	A **B** **C** **D**	**4** **32** **3** **3**
3/26/03	**Providing Interpretation Services Training.** **Presenter: Myriam Aragon, LMFT**	A **B** **C** **D**	**2** **6** **3** **4**

		E	**3**
04/30/03	**Providing Interpretation Services Training. Presenter: Myriam Aragon, LMFT**	A **B** **C** **D**	**4** **21** **5** **9**
5/2/03	**Mega Answers to ADHD Presenter: John Taylor, PhD**	A **B** **F**	**12** **38** **76**
6/4/03	**Satellite-Cross-Cultural in Health Care. Presenter: Shani Dowd Robert Like**	A **B**	**5** **6**
6/18/03	**Recovery Assessment and Treatment Systems. Presenter: Dr. Ebbe**	A **B** **C** **D**	**8** **27** **2** **7**
6/18-19/03	**Training the Trainers Presenter: Ada Albright Joanne Harwick**	A **B**	**3** **11**
6/20/03	**Substance Abuse and Domestic Violence. Presenter: Tina Gordon**	A **B** **C** **D**	**4** **17** **5** **4**
4/25/03	**Women & Trauma Presenter: Tina Gordon**	A **B** **C** **D**	**3** **18** **5** **4**
6/23/03	**Confidentiality. HiPPA, & Ethics Presenter: Mary Jane**	A **B**	**5** **11**
6/25/03	**Providing Interpretation Services. Presenter: Myriam Aragon, LMFT**	A **B** E	**1** **2** **14**
07/01/03	**Recovery Assessment and Treatment Systems Presenter: Dr. Ebbe**	A **B** **D**	**16** **78** **12**
07/07/03	**Recovery Assessment and Treatment Systems Presenter: Dr. Ebbe**	A **B** **D**	**10** **60** **20**

6/18/03	**Recovery Assessment and Treatment Systems Presenter: Dr. Ebbe**	A **B** **D**	**9** **62** **17**
7/17-18/03	**The Experience of Hearing Voices. Presenter: Dr. Ebbe**	A **B** **C** **D**	**5** **35** **6** **8**
8/21/03	**Group Therapy Presenter: Ralph Ortiz Hours: 4**	A **B** **C** **D**	**15** **86** **11** **3**
4/25/03	**Women & Trauma Presenter: Tina Gordon**	No data available	**30**
10-17-03	**Addition Treatment Trends and Strategies. Presenter: Ronald Williams, PhD. Ontrack Program Resources.**	A **B** **C** **D** E **F**	**9** **76** **24** **15** **5** **54**
11-21-03	**Law and Ethics for Mental Health Providers. Presenter: Linda Garret, ID Parner Risk Management Services**	A **B** **C** **D** E **F** **G**	**10** **31** **8** **15** **9** **4** **0**

Although all trainings incorporated cultural considerations, the department has provided additional cultural competence specific trainings to meet the need of our staff and population served. The following is the list of cultural competence specific training during the year 2002-2003:

Table 81
MHP 2002 – 2003
Cultural Competence Training:

List of trainings by functions:

A) Administration Management (clinic supervisors, Program Managers, Deputy Directors)
B) Direct Services: MHP's staff
C) Direct Services: Contractors
D) Support services (includes clerical staff, staff analysts, data entry)
E) Interpreters.
F) Other: General Public, consumers, community agencies
G) Unknown

DATE	Training	Attendees by Function	# Of Attendees
01/02/02	**Treatment Issues & Cultural Competence with Native American population**	A **B** **C** **D**	**9** **45** **12** **3**
03/20/02	**Gay & Lesbian Diversity Issues Presenter: Peter Nordi**	A **B** **C** D	**15** **43** **18** **7**
03/12/02	**Principles for Determination of Length & Type of Treatment**	A **B** **C**	**7** **23** **5**
4/24/02	**Int. Spirituality & Psychology. Presenter: Al Dueck**	A **B** **C** **D**	**14** **42** **6** **4**
6/21/02	**Psychotherapy with Gay and Lesbians, and Bi-sexuals. Presenter: J.M. Evosevich**	A **B** **C** **D**	**7** **25** **3** **6**
9/19/02	**Latino Behavioral Week Celebration**	**H**	**300**
9/23/02	**Orientation to Mental Health Recovery vision/ The consumer perspective. Presenter: Amy Long**	A **B** **C** **D**	**57** **241** **14** **45**
10/23/02	**Engaging clients in the Recovery. Presenter: Kim Dmetz**	A **B** **C** **D**	**26** **112** **7** **18**

10/18/02	**Impact of Mental Illness on Family.** **Presenter: Marshal Jung**	A **B** **C** **D**	**9** **16** **2** **3**
11/12/02	**Interacting with Consumer Programs.** **Presenter: Chris Amenson**	A **B** **C** **D**	**15** **53** **4** **9**
11/21/02	**Interacting w/ Consumer Programs.** **Presenter: Chris Amenson**	A **B** **C** **D**	**21** **134** **13** **35**
11/22/02	**Native American Cultural Awareness**	**A** **B** **D** **F**	**25** **100** **35** **8**
12/3-4/02	**Culturally Competent Tx Planning.** **Presenter: Neal Adams, Ed Diksa**	A **B**	**68** **44**
3/6,13,20,27/03	**Child Abuse Prevention Spanish Speaking Radio Program**	**H**	**300**
3/28/03	**Diagnosing & Identifying** Dual Disorder. **Presenter: Tina Gordon**	A **B** **C** **D**	**4** **32** **3** **3**
3/26/03	**Providing Interpretation Services Training.** **Presenter: Myriam Aragon**	A **B** **C** **D** E	**12** **6** **3** **4** **3**
04/30/03	**Providing Interpretation Services Training.** **Presenter: Myriam Aragon**	A **B** **C** **D** E	**4** **21** **5** **9**
5/15/03	**May is Mental Health Month – Spanish Speaking Radio Program**	**H**	**300**
5/19-23/03	**May is Mental Health Month – Art Exhibition**	**H**	**345**
5/27/03	**Asian American/Pacific Islander Celebration**	**A** **B** **D** **F**	**25** **100** **35** **8**
6/25/03	**Providing Interpretation Services Training.** **Presenter: Myriam Aragon**	A **B** **C** **D** E	**1** **2** **14**

7/17-18/03	**The Experience Of Hearing Voices**	A **B** **C** **D**	**5** **35** **6** **8**
7/29	**European American Celebration**	**A** **B** **D** **F**	**25** **100** **35** **8**
7/30/03	**Providing Interpretation Services Training. Presenter: Myriam Aragon**	A **B** **C** **D** E	 **2** **7** **2** **9**
8/9/03	**Parents Rally**	**H**	**68**
8/20/03	**Providing Interpretation Services Training. Presenter: Myriam Aragon**	A **B** **C** **D**	**2** **6** **1** **10**
8/21/03	**Group Therapy. Presenter: Ralph Ortiz**	A **B** **C** **D**	**15** **86** **11** **3**
9/12/03	**Celebrating Latino Behavioral Health Month Potluck – Ujima Counseling Center**	**A** **B** **D** **F**	**30** **40** **25** **10**
9/19/03	**Cultural and Linguistic Community Advisory Meeting**	A F	**1** **25**
9/29/03	**Latino Behavioral Halth Week**	**A** **B** **D** **F**	**20** **80** **35** **40**
10/12-10/03	**Semana Binacional de Salud / Bi-national Health Week III**	**H**	**600**
12/11/03	**Depression Information Spanish speaking Radio Program**	**F**	**300**

For all the trainings provided by outside vendors, an Educational Assistance Proposal (EAP) form is submitted to the administration for tracking purposes. The list of cultural competence outside vendors trainings received by DBH staff is the following:

Table 82
DBH 2002 – 2003
Cultural Competence
Outside Agencies/Resource Trainings

List of trainings by functions:

A) Administration Management (clinic supervisors, Program Managers, Deputy Directors)
B) Direct Services: MHP's staff
C) Direct Services: Contractors
H) Support services (includes clerical staff, staff analysts, data entry)
I) Interpreters.
J) Other: General Public, consumers, community agencies
K) Unknown

Date	Training Description	Attendees by Function	# of Attendees
2-6-02 **2-7-02** **2-8-02**	**Many Voices, one Direction: Building A Common Agenda For Cultural Competence In Mental Health**	A **B**	**2** **1**
9-24-02	**Latino Behavioral Health Conference**	A **B**	**1** **2**
11-6-02 **11-7-02**	**Cultural Competence and Mental Health Summit X** **Strength in Diversity: Concept to Action**	A **B** **D**	**40** **41** **10**
1-29-03	**Bi-National Conference. Imperial County**	A **B**	**1** **2**
3-20-03	**Latino Access Study Strategies on How to Design a Latino Access study. San Diego, Ca**	A **B**	**2** **1**
6-17-03	**Evidence Based Practice. Today, Tomorrow and Into the Future**	A **B**	**2** **2**
9-18-03	**Making a Difference for Children. Redesigning the Child Welfare System. Children Network Conference**	A **B** **D**	**10** **6** **2**
11-19-03 **11-20-03**	**Cultural Competence and Mental Health Summit XI**	A **B** **D**	**4** **5** **3**

12-5-03	**Ventura County Latino Task Force Conference**	A	**1**

In addition to the information on trainings that DBH staff received, the cultural competence unit collected information regarding trainings received by the DBH contract agencies. Although the majority of the contract agencies' staff received their trainings through DBH, the contract agencies' staff attended a few cultural competence trainings provided by outside vendors. The following is the list of cultural competence specific training received by contract agencies' staff :

Table 83
2002 – 2003 Cultural Competence Training
Provided by Contract Agencies:

List of trainings by functions:

- **H) Administration Management**
- **I) Direct Services: MHP's staff**
- **J) Direct Services: Contractors**
- **K) Support services**
- **L) Interpreters.**
- **M) Other: General Public, consumers, community agencies**
- **N) Unknown**

Date	Training Description	Attendees by Function	# Of Attendees
Central Valley Region			
01-2003	**Working with Residents who have special Problems (Blindness, Deafness, etc)**	**C A D**	**8 1 1**
04- 2003	**Non-Psychiatric Versus Psychiatric Socio-cultural Factors related to Treatment and Communication**	**C A D**	**8 1 1**
4-22-03	**Client Centered Approach**	**C**	**1**
5-1-03	**Recovery**	**C**	**1**
6-12-03	**Cultural Competence**	**C A D**	**8 1 1**
7-1-03	**Cultural Competence**	**C**	**8**

		A **D**	**1** **1**
9-9-03	**Cultural Competence**	**C** **A** **D**	**8** **1** **1**
10-8-03	**Interpersonal Relationship Communication/Building Trust**	**C** **A** **D**	**8** **1** **1**
10-8-03	**Diversity Advantage**	**C** **A** **D**	**8** **1** **1**
10-22-03	**Cultural Competence Training**	**C** **A**	**4** **1**
10-2003	**Heterosexual Behaviors and Homosexual Behaviors in the Psychiatric Setting**	**C** **A**	**8** **1**
12-2003	**Spirituality and Chronic Psychiatric Residents**	**C** **A**	**8** **1**
West Valley Region			
2-26-02	**Divorce & Step-Parent Issues**	**C** **A**	**3** **1**
3-12-02	**Learning Disability**	**C**	**4**
3-26-02	**Cultural Issues & Case Presentations**	**C**	**4**
6-2003	**Cultural Play Therapy**	**C**	**4**
7-24-03	**Engaging Diverse Population**	**C**	**1**
9-23-03	**Latino Behavioral Health Conference**	**C**	**2**
East Valley Region			
4-16-03	**Diversity in the Workplace**	**C** **A**	**7** **1**
5-15-03	**Cultural Sensitivity**	**C** **A**	**7** **1**
11-12-03	**Cultural Competence in Clinical Supervision**	**C** **A**	**7** **1**
11-19- 03	**Cultural Competence and Mental Health Summit**	**A**	**2**
11-2--03	**Cultural Competence and Mental Health Summit**	**A**	**2**

Desert Mountain Valley Region			
2-4-03	**Getting to know your clients**	**C A D**	**5 2 1**
6-2003	**Recovery Model**	**C A D**	**5 2 1**
7-25,26-03	**Living in the mind of God**	**C**	**1**
4/23-25/03	**Working with Adolescents & Family**	**C**	**1**
9-24-03	**Working with Aging Parents**	**C**	**1**
9-27-03	**Working with Aging Parents**	**C**	**1**

IDENTIFICATION OF TRAINING NEEDS:

Staff Cultural Competence Assessment

On June 2002, the Cultural Competence Department measured self-report multicultural competencies of all the mental health staff. The Measured was done using the California Brief Multicultural Competence Scale (CBMCS) Gamst, G., Dana, R.H., Der-Karabetian, A., Aragon, M., Arellano, L., Morrow, G. & Martenson, L. (In Press).

The CBMCS is a 21- item scale specifically developed to measure self-report multicultural competency of practitioners who provide mental health services. The instrument measures four cultural competence factors: Knowledge, Awareness, Sensitivity, and Non Ethnic Ability. Two pages with demographic information and the 21 questionnaires are presented in attachment 8.

OVERALL CBMCS DBH SCORES

For broader description of staff levels of competence, tables were created to allow competence to be described as Low, Medium or High using the total scores.

Table 84
Total Scale Scores

Job Classification	Number of staff	Level of competence
Psychologist	34	High
Psychiatrist	40	Medium
MFT/MSW/LCSW	159	High
Nursing	17	Medium
Social Worker	37	Medium
Occupational Therapist	18	Low
Psychiatric Technician	7	Medium
Administration Management/Admn Support	54	Low
Paraprofessional	55	Medium
Clerical	147	Low
Other	36	Low
ALL TYPES	604	Low

Table 85
All classification overall scores

Subscales	# Of staff	Level of competence
Awareness	**603**	**Medium**
Knowledge	**596**	**Medium**
Non-ethnic	**592**	**Low**
Sensitivity	**598**	**Medium**

Note: There was a total of 604 DBH staff that completed the CBMCS survey.

CULTURAL COMPETENCE TRAINING PLAN

The staff cultural competence assessment scores is used as a baseline to develop a multicultural training program to help staff on the areas of concern and by job classifications. The next step for this coming year is to strategically plan the following four goals:

- **Goal # 1**

  Provide cultural competence training to all DBH clerical staff.

  Objectives

1. Develop a cultural competence-training program with the assistance of Program Managers and Supervisors to provide clerical staff with information on cultural considerations and costumer services in a multicultural environment.
2. Provide training to all clerical staff in all regions.

- **Goal # 2**

  Provide cultural competence training to all Administration and Administration support staff at DBH.

  Objectives:

1. Develop a 4-hour cultural competence-training curriculum for administration and support staff.
2. Provide training to all administration and administration support staff

- **Goal # 3**

  Continue the development of cultural competence training curriculum for direct service providers.

Objectives:

1. Continue interpretation training 4 times a year
2. Provide cultural considerations/clinical assessment training once a year
3. Provide cultural competence supervision training once a year

- **Goal # 4**

  Conduct a Contract Agencies Staff Cultural Competence Assessment.

  Objective:

1. Measure self-report multicultural competencies of all the contract agencies' staff. The Measure will be done using the California Brief Multicultural Competence Scale (CBMCS) Gamst, G., Dana, R.H., Der-Karabetian, A., Aragon, M., Arellano, L., Morrow, G. & Martenson, L. (In Press).
2. Provide the training recommended by the California Brief Multicultural Competence Scale Project.

Part IV:
Cultural Competence Plan
Selected Requirements

CCP SELECTED REQUIREMENTS

In response to the County's changing needs, the MHP conducts several ongoing activities to ensure that the service delivery system is responding to the identified needs of our diverse communities. The Following are the activities conducted by the MHP in order to identify and respond to the needs of the communities served:

1. Department Facilities SPM
2. Capital Improvement Program
3. MHP Quality Improvement Program
4. Latino Access Study
5. Consumer Feedback via focus Groups
6. Consumer Council/Consumer Advisory Boards

Department Facilities Standard Practice:

The director approved a standard practice on the Review of Department Facilities. The Quality Improvement Unit and Cultural Competency Unit review and monitor the compliance of the SPM. The purpose of this standard practice is to establish a yearly review of all service sites. The emphases of the reviews are to ensure DBH sites are inviting and accessible to diverse populations. The review assesses location, transportation, hours of operation, and other relevant areas, including the locating of facilities in settings that are non-threatening, co-location of services and/or partnership with community groups.

The Capital Improvement Program:

The Capital Improvement Program procedure is used by the Board-Governed District to request approval to lease or expand leased space or to vacate, occupy, alter, remodel or construct county owned space, land, or facilities. The Capital Improvement Program Request includes information regarding accessibility, public transportation, public waiting areas, restrooms, and other special requirements. Additionally, access to public transportation as a requirement, the department has a transportation unit that provides transportation to and from appointments, if transportation is a barrier.

MHP Quality Improvement Program:

The San Bernardino Mental Health Plan Quality Improvement Program is committed to maintain and improve the quality of the clinical and administrative delivery system to meet the service needs of our culturally diverse populations.

An annual evaluation of the overall effectiveness of the Quality improvement program is essential to ensuring that quality improvement activities have contributed to the meaningful improvement in clinical care and beneficiary services. The effectiveness of the program is measured by the identification of the quality of care issues and service barriers that affect beneficiaries, tracking of these issues over time to ensure follow up of the QI process, and recommend policy and systematic changes. Quality of care issues are identify through the following functions:

Monitoring the accessibility of services

In addition to meeting Statewide standards, the MHP have set goals for the timeless of routine mental health appointments; timeliness of service for urgent conditions; access to after hours care and responsiveness of the MHP's 24-hours, toll free telephone number.
Objective: The MHP will meet the following guidelines for timeliness in the authorization decision of services:

- Within 14 working days of receipt of completed request for routine mental health appointments.
- Immediately upon presentation for urgent conditions
- 24-hour, 7 days per week access to after hours services via MHP's toll free number

Monitoring the service delivery capacity of the Mental Health Plan

The Mental Health Plan has implemented mechanism to ensure the capacity of service delivery within the MHP. This include:

- The MHP describe the current number, types and geographic distribution of mental health services within its delivery system, including the network Fee-for – Service licensed providers.
- The MHP set goals for the number, type and geographic distribution of mental health services

In addition to location the MHP administrators consider hours of operation and transportation issues when making contract and/ or sitting decisions. Each of the regions has programs that operate beyond an 8AM-5PM day. These programs operate into the evening to accommodate working adults and families.

Monitoring of Beneficiary Satisfaction

The MHP conducts a series of beneficiary/family satisfaction survey yearly. In addition inform the providers of the results, evaluate Beneficiary Grievances and State Fair Hearings, and request to change person-providing services. The following are the Beneficiary/Family Satisfaction Surveys:

- Service Satisfaction Survey for FFS Providers
- State Performance Outcome Evaluation System Satisfaction Survey
- Mental health Statistics Improvement Program (MHSIP) Consumer Survey (attachment # 9)
- Threshold Language Survey (attachment # 10).

The Mental Health Statistics Improvement Program (MHSIP) Consumer survey and the Threshold Language Survey are translated to Spanish, which is the county's identified threshold language.

The results of the surveys are analyzed by the Research and evaluation unit and presented to administration, providers, and Quality Improvement committees for review and recommendations. The results are also analyzed by racial/ethnic background to determine the experiences ethnic minorities have with the utilizing mental health services.

LATINO ACCESS STUDY:

On October 3, 2001 the State Department Quality Improvement Committee (QIC) meeting adopted the following requirement: " Counties with Medi-Cal eligible population of 10,000 or more and/or counties with Spanish as one of their threshold languages will be required to do and/or add a Latino Access Study to their Annual Quality Improvement Work plan with an over-all goal to improve Latino access to mental health services"

The Quality Improvement Plan was amended to include the Latino Access Study to be part of the Department of Behavioral Health Mental Health Plan. The Department's Cultural Competence Unit and Compliance Unit created a task force. Several meeting were held to develop a collaborative approach to design and implement the study.

The Task- force agreed that the study would examine the retention rate and identify barriers to culturally competent services of beneficiaries who receive only one outpatient clinic visit. The study will examine cultural, linguistic and geographical factors that may be associated with retention at county outpatient clinics. Factors may include the consumer's preferred language, therapist and psychiatrist linguistic capabilities, presenting problem, diagnosis, treatment disposition, and referral source. The study will include an analysis of automated administrative data, chart review and consumer survey to identify factors that impact the retention rates.

The study is composed of three phases:

- First phase is data collection and analysis
- Second phase is the chart review
- Third phase consumer interviews.

Partial results of the study can be found in attachment # 11.

CONSUMER FEEDBACK:

Consumer Focus Groups

The County of San Bernardino Department of Behavioral Health is committee to gain input from consumers, their families and potential consumers on their experiences in accessing specialty mental health services. According to the Standard Policy Practice, signed by the director on June 6, 2000, meeting with consumers are to be held quarterly in each region. Notes of the Focus Group meetings, along with the sign- up list are to be forwarded to the Cultural Competence Unit. The purpose of the focus groups is to gain input from DBH consumers, their families or potential consumers on their experiences in accessing specialty mental health services. The goal is to improve accessibility to specialty mental health services by identifying and removing barriers to treatment.

The Cultural Competence Unit has reviewed the Focus Group notes conducted during the year 2002-2003 and has identified salient issues that required consideration and action plans for improvement:

ISSUE # 1 - Transportation availability

Action Plan:

- Distribution of Access Unit list of program and services both in English and Spanish.
- Distribution of Caltran's Bus schedules and maps at each clinic.

ISSUE #2 - Bilingual staff and bilingual services availability

Action Plan:

- On April 2003 the Cultural Competence Unit conducted an Interpreters Service Report/ analysis. The report provided the department with recommendations base on budget impact and quality of care issue. The information on the study is presented on attachment # 12.
- The Cultural Competence Unit reviewed the policy regarding satisfying consumer language needs to ensured that consumers have access to appropriate linguistic services primarily through qualified department staff, to establish guidelines for interpreter services including sign language via department's staff, and to establish guidelines, including sign language, via outside vendors. (Attachment #13)
- The Cultural Competence Unit develop a Translation policy of Written Materials to provide standards and guidelines for translating consumer information materials, forms, and any other written document into another language; to ensure that all consumer information materials, forms and any other written documents are translated into the threshold language identified by the department of Behavioral Health based on the state criteria; and to monitor the quality, distribution and availability of translated information materials, forms and any other written documents for DBH sites. (SEE ATTACHMENT 14)
- The Cultural Competence Unit created the Translation subcommittee that is currently working on the translation to Spanish of all the forms that are giving to consumers.

ISSUE #3 - Lack of information about consumers rights and available services in other languages different than English.

Action Plan:

- Cultural Competence Unit review and distributed the Consumer's Guide in both English and Spanish for distribution to all sites
- Cultural Competence Unit issue posters in English and Spanish of Consumers right to receive services in their preferred language.

- Cultural Competence Unit issue posters in English and Spanish about the Consumer Guide availability in clients preferred language and audiotapes for visual impaired**.**

ISSUE # 4 - Lack of ethnic specific Treatment groups.

Action Plan:

- Locate community resources for referrals to community ethnic specific groups and provide a resource list to all clinics for distribution among clients and service providers
- Develop a list of all groups done at the Department of Behavioral health through all the clinics for distribution and referral purposes.
- Have consumers councils participation in program development to addressed the issue

ISSUE #5 - Need to increase resources in the rural areas.

Action Plan:

- Conduct community needs assessment in rural areas of the county.
- Develop strategic plan to meet the mental health needs of rural areas

ISSUE #6 - Not enough number of consumer groups to act as advocacy/or advisory board.

Action Plan:

- Create additional client councils within regions
- Recruit more clients for client's councils

CONSUMER COUNCIL/COUNSUMER ADVISORY BOARDS:

For the last year the Department of Behavioral Health has been conducting Consumer Regional Council. The Consumer Regional Council meets once a month, rotating between clinics in each region. The makeup and purpose of the council is as follow:

- Representatives from the local clinic councils are usually sent to attend the monthly meetings. While the representatives are usually officers or members of the clinic council, designated consumer can be sent to attend as decided by the consumers at the clinics.
- Consumers designated to attend the regional council meeting poll the local clinic consumers as to what issues they would like to be addressed at the regional meetings. These issues can be of a wide variety and range from staffing and treatment change issues to efforts to promote united advocacy issues among a larger sampling of consumers.
- A representative from regional management is usually present at the meetings to note and report on changes and issues occurring within the department and request feedback.
- The consumers select a council chairperson and recorder and minutes are taken forwarded to the program manager and the DBH Director.
- The regional council meeting may also be used as a forum to share events and activities at various clinics and coordinate joint clinic activities among the consumers.

Action plan for next year:

1. Consumer council minutes to be filed and analyze by cultural competence committee for identification of issues and develop strategy planning to create problem resolution.

2. Consumer council group to have representation on cultural competence committee meeting and program planning meeting via cultural competence consumer advisory board.

3. Diversification of consumer's representation in the consumer council meeting by having representation of consumers from different ethnic groups.

4. Consumer's council groups to represent the linguistic threshold language of our consumers.

Monitoring of Facilities environment:

The County of San Bernardino Department of Behavioral Health's Cultural competence unit has also develop polices and procedures for the development of written material, including posters in languages other than English. The cultural competence committee has the function of conducting random inspections of facilities to evaluate their environment base on the facility inspection checklist. An analysis of the results of the facility inspection is provided to the program managers for the development of an action plan of correction (see attachment 15).

Studies and Analysis of factors above:

The Latino Access Study, the Consumer Feedback via Focus Group analysis, and the MHSIP consumer survey report have been submitted to the Administrative Team. The Administrative Team is looking at resources given budget constraints and is attempting to facilitate access to clients. Furthermore, the Cultural Competency Committee has been charged to come up with strategies that are not costly and that will target ethnic populations.

PENETRATION – RETENTION

Comparison of Ethnic Groups in the Medi-cal Beneficiary Population:

Table 87
Ethnicity and Age

	Minor		Adult		Total	
Ethnicity	**Count**	**%**	**Count**	**%**	**Count**	**%**
African American	2192	46.46%	2526	53.54%	4718	100%
American Indian	128	45.55%	153	54.45%	281	100%
Asian American	67	9.94%	607	90.06%	674	100%
European American	4621	39.31%	7134	60.69%	11755	100%
Latino	2746	46.19%	3199	53.81%	5945	100%
Multiple	36	37.50%	65	62.50%	104	100%
TOTAL	9793	41.71%	13684	58.29%	23477	100%

The penetration rate by ethnicity and age indicates that the county of San Bernardino provided 58.29% of services to adults and 41.71% to minors. The penetration rate of Asian American minors is significantly low.

Table 88
Ethnicity by Region

	East Valley		Desert/Mountain		Central Valley		West Valley		Total	
Ethnicity	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**
African Am.	625	20.78%	621	20.64%	1149	38%	613	20%	3008	100%
American Indian	21	11.29%	70	37.63%	70	38%	25	13%	186	100%
Asian Am.	46	10.50%	33	7.53%	113	26%	246	56%	438	100%
European Am.	714	9.15%	3255	41.73%	2481	32%	1351	17%	7801	100%
Latino	727	18.67%	630	16.18%	1359	35%	1177	30%	3893	100%
Multiple	6	8.33%	21	29.17%	22	31%	23	32%	72	100%
TOTAL	2139	13.89%	4630	30.07%	5194	34%	3435	22%	15398	100%

Table 89
Ethnicity by Gender

	Unknown		Male		Female		Total	
Ethnicity	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**
African Am.	8	0.17%	2323	49.24%	2387	51%	4718	100%
American Indian			128	45.55%	153	54%	281	100%
Asian Am.			327	48.52%	347	51%	674	100%
European Am.	22	0.19%	5682	48.34%	6051	51%	11755	100%
Latino	2	0.03%	2902	48.81%	3041	51%	5945	100%
Multiple			57	54.81%	47	45%	104	100%
TOTAL	32	0.13%	11419	49.21%	12026	51%	23477	100%

Penetration rates by ethnicity and gender indicate no significant difference among all groups.

Table 90
Penetration Rate by Ethnic Group Comparison of October 02 and October 03

	OCTOBER 02					OCTOBER 03				
ETHNIC GROUP	MEDI-CAL BENEFICIARIES		COUNTY CLIENTS		PERCENT DIFFERENCE	MEDI-CAL BENEFICIARIES		COUNTY CLIENTS		PERCENT DIFFERENCE
	N	%	N	%		N	%	N	%	
African American	48824	15	3327	17	+2	50366	15	4428	17	+2
Native American	1723	1	225	1	0	1709	1	301	1	0
Asian American	24326	8	465	2	-6	14285	4	696	3	-1
Euro – American	95323	29	9941	51	+23	95878	28	12980	50	+22
Latin American	140853	44	4635	24	-20	163354	48	6152	24	-24
Other/ Unknown	12571	4	791	4	0	15922	5	1410	5	0
TOTAL	323620	101	19384	100		341514	100	25967	100	

PENETRATION RATES BY ETHNIC GROUP

Table 88 shows the penetration rate by ethnic group for the October 2002 and October 2003. In San Bernardino County during October 2002, the Latino-Americans make up 44 percent of the Medi-Cal beneficiaries, followed by Euro-Americans at 29%. African Americans made up 15 percent of the Medi-Cal beneficiaries. During October 2003, the percentages are similar in order, but the percent of Latino- American beneficiaries increased to 48, whereas the Asian Americans fell to 4 percent. The African-Americans and Native Americans remained the same. Euro-Americans decreased by 1 percent and the other/unknown increased by 1 percent.

Table 88 also shows the ethnic breakdown of the client population during the same time periods. The percentage for ethnic distributions was computed using the make up the open episodes during the two time periods. For October 2002, the client population consisted of a majority of Euro-Americans at 51 percent. The next highest is Latino-American at 24 percent, followed by African-Americans at 17 percent.

When the make up of the client ethnic episodes are compared with the County of San Bernardino Medi-Cal beneficiaries, distinct differences are noted. During October 2002

the largest percent of client episodes were for Euro-Americans. At 51 percent, client episodes for Euro-Americans were much higher than the proportion in the Medi-Cal beneficiary population. On the other hand, the percent of Latino American client episodes was much lower than the proportion of Medi-Cal Latino-American beneficiaries in the County. Moreover, the percent of Asian-American episodes was much lower than the percent of Asian-American Medi-Cal beneficiaries. The percent of African-American episodes was slighter higher than the percent of African-American Medi-Cal beneficiaries. The findings are consistent with other studies which show the Latin-American clients are underrepresented and African-American are generally over-represented.

Similarly, during October 2003, the findings were very similar. The percent of Latino-American in the population of Medi-Cal beneficiaries increased to 48 percent of the total Medi-Cal beneficiaries, whereas the Latino-American client episodes remained at the same level (24 percent) as in October 2002. The Asian-American beneficiaries decreased from October 2002 to 2003 (from 8 percent to 4 percent), but the percent of Asian-American client episodes slightly increased from 2 to 3 percent. African American and Native–American remained at the same level.

The findings showed that there was large variance between the percent of Latino-Americans in the Medi-Cal beneficiary population and percent of Latino-Americans in the San Bernardino County Department of Behavioral Health (SBCDBH) client episodes for the same time period. The number of Medi-Cal beneficiaries is increasing, and the percent of Latino-Americans that make up the beneficiary population is increasing. However, the DBH client episode data indicate that Latino-American Medi-Cal beneficiaries may be underserved. These findings indicate that the department must examine the service delivery system and the barriers, which may exist to these clients accessing mental health services. Again, consistent with previous findings, the African-American client appears to receive services at a higher level than their percentage in the population.

RETENTION RATES

Retention rate is defined as our average number of visits that the client received (discharge only).

Table 91

RETENTION RATE AS MEASURED BY THE NUMBER OF VISITS RECEIVED BY GROUP DURING FISCAL YEAR 02-03				
ETHNICITY	**FEMALE**	**MALE**	**UNKNOWN**	**ETHNIC TOTAL**
AMER. IND.	**2.80**	**2.97**		**2.88**
ASIAN	**2.11**	**2.37**		**2.23**
AFRICAN AMERICAN	**2.80**	**2.86**	**2.75**	**2.82**
LATINO	**2.97**	**2.96**	**1.25**	**2.97**
MULTIPLE	**1.25**	**1.67**		**1.43**
OTHER	**2.93**	**2.70**		**2.81**
UNKNOWN	**2.49**	**2.50**	**2.82**	**2.50**
WHITE	**2.81**	**2.85**	**2.41**	**2.83**
GRAND TOTAL	**2.82**	**2.86**	**2.47**	**2.84**

Source: SIMON System 2002-2003

Table 92

RETENTION RATE BY AGE GROUP DURING FISCAL YEAR 03-02					
ETHNICITY	**0-17**	**18-39**	**40-59**	**60+**	**ETHNIC TOTAL**
AMER. IND.	**3.27**	**2.64**	**2.86**	**2.00**	**2.88**
ASIAN	**3.16**	**2.52**	**1.95**	**1.73**	**2.26**
AFRICAN AMERICAN	**3.14**	**2.72**	**2.66**	**2.46**	**2.85**
LATINO	**3.26**	**2.77**	**2.81**	**2.59**	**2.96**
EURO-AMERICAN	**3.26**	**2.68**	**2.67**	**2.36**	**2.85**
OTHER/ UNKNOWN	**2.59**	**2.58**	**2.67**	**2.35**	**2.60**
GRAND TOTAL	**3.20**	**2.71**	**2.68**	**2.36**	**2.86**

Table 93

RETENTION RATE BY DIAGNOSTIC CODE FOR ETHNIC GROUPS									
ETHNICITY	ADHD/ ADD	ADJUST-MENT	ANXIETY	BEHAVIOR	DEPRESSION MOOD	MAJOR DEPRESSION	PSYCHOSIS	OTHER	ETHNIC TOTAL
AMER. IND.	3.02	3.75	2.29	3.36	3.05	2.99	1.44	3.26	2.88
ASIAN	1.85	3.36	2.00	2.80	3.07	2.43	1.45	3.09	2.23
AFRICAN AMERICAN	3.32	3.86	1.93	2.86	3.30	3.06	1.63	3.10	2.83
LATINO	3.43	3.74	1.82	3.21	3.58	3.10	1.74	3.14	2.97
MULTIPLE					2.00		1.40	1.00	1.41
OTHER	3.69	3.67	1.67	3.25	3.09	2.79	1.48	2.87	2.81
UNKNOWN	3.09	3.44	2.16	3.56	2.65	2.99	1.52	2.24	2.50
WHITE	3.30	3.65	1.93	3.34	2.99	3.01	1.66	2.85	2.83
GRAND TOTAL	3.27	3.69	1.92	3.22	3.23	3.03	1.66	2.98	2.84

Table 94

RETENTION RATE BY PRIMARY LANGUAGE DURING FISCAL YEAR 03-02					
ETHNICITY	ENGLISH	SPANISH	OTHER	UNKNOWN	ETHNIC TOTAL
AMER. IND.	2.87	3.00	3.23		2.88
ASIAN	2.66	3.86	1.81		2.26
AFRICAN AMERICAN	2.87	2.18	2.54		2.85
LATINO	2.97	2.98	2.66		2.96
EURO-AMERICAN	2.87	2.10	2.37		2.85
OTHER/ UNKNOWN	2.68	2.00	2.62	1.46	2.60
GRAND TOTAL	2.89	2.96	2.45	1.46	2.86

Analysis:

Three major factors where illustrated by the tables above. These factors are that 1) Children received more visits 2) Asian-Americans had the lowest overall, as far as unit of service and 3) Latinos have poor penetration rates, but their retention rate is the same as Caucasians.

Penetration rate for Latinos appears to be quite low particularly when on looks at the ever-increasing proportion of Latinos in the Medi-cal beneficiary population. It has increased by 4% within one year and is nearing 50% of the medi-cal beneficiaries. Therefore, our resources will be allocated to improving penetration rates of the Latino ethnic group to 3% overall. This modest goal since at this time we have very limited resources, but the Cultural Competency Committee is charged with identifying the least costly ways to decrease barriers and facilitate access of the Latino population to Mental Health services.

Since data indicate that retention is not an issue for the Latino population, we will not establish a percent improvement for retention rate at this time.

ATTACHMENTS

ATTACHMENT 1

Monthly Medi-Cal Productivity and Penetration Report

Attachment #1

Site: **Rancho** Month: **July 2003** Provider FTE's = **10** Annual Staff Hours = **16500**

DAY TREATMENT (Day treatment data is not included in other service types or in Grand Total below)

(For sites with day treatment, FTE's shown above have been reduced by 1.5 FTE -- expected daily census is 13 clients)

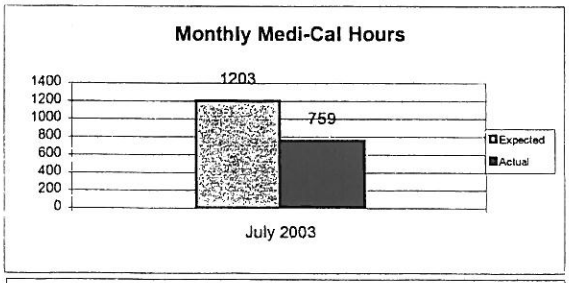
(Day Treatment is tracked in client days	Monthly Target	Monthly Actual	Variance	% Difference	Target FYTD	Actual FYTD	Variance FYTD	% Diff FYTD	Annual Goal	% of Annual Goal
Day Treatment (all ages)	0	0	0	0	0	0	0%	0	n/a	n/a

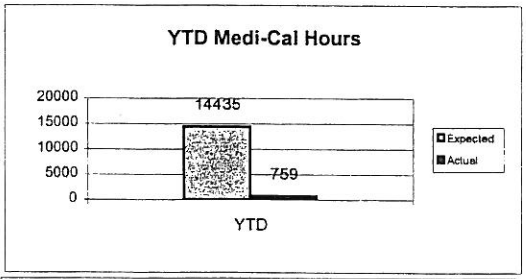
MHS, CM and MEDICATIONS SERVICES SHOWN BELOW

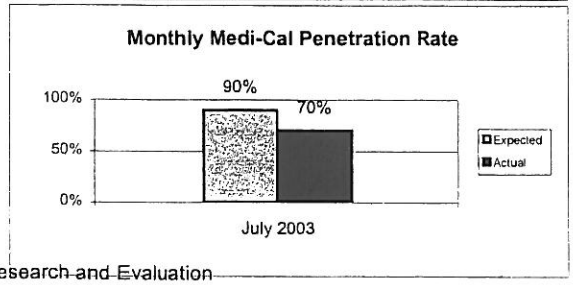
(For each Clinic Supervisor, FTE's shown above have been reduced by .5)

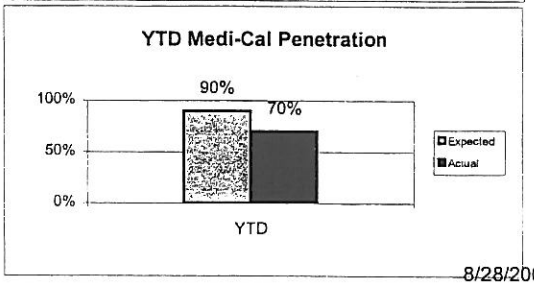
Outpatient expected penetration rates are: Adult 85%, Child 95%

Target Group	Service Type	Month: Hours Expected	Hours Actual	Variance Hours	Variance Percent	Year-to-Date: Hours Expected	Hours Actual	Variance Hours	Variance Percent	Annual Goal (Hours)	% of Annual Goal to Date
Projected Age Split	50% Adults 50% Minor					**Actual Monthly Split**		43% Adults		57% Minors	
Exceeds Upper Limit ( )											
DIRECT SERVICE HOURS (Represents 65% of Annual Goal for Billed Hours)											
Adult	CM	112	113	+1	+1%	1341	113	-1228	-92%		
	Crisis	56	3	-53	-95%	670	3	-667	-100%		
	Medications	140	131	-9	-6%	1676	131	-1545	-92%		
	MHS	251	163	-88	-35%	3017	163	-2854	-95%		
	Subtotal	**559**	**410**	**-149**	**-27%**	**6705**	**410**	**-6295**	**-94%**	**6705**	6.1%
	Medi-cal	**475**	**250**	**-225**	**-47%**	**5699**	**250**	**-5449**	**-96%**		
	Maximum Non-Medi-cal	**84**	**(160)**	**-76**	**(91%)**	**1006**	**160**	**+846**	**+84%**		
Minors	CM	112	80	-32	-28%	1341	80	-1261	-94%		
	Crisis	56	0	-56	-100%	670	0	-670	-100%		
	Medications	140	70	-70	-50%	1676	70	-1606	-96%		
	MHS	251	401	+150	+59%	3017	401	-2616	-87%		
	Subtotal	**559**	**551**	**-8**	**-1%**	**6705**	**551**	**-6154**	**-92%**	**6705**	8.2%
	Medi-cal	**531**	**387**	**-144**	**-27%**	**6370**	**387**	**-5983**	**-94%**		
	Maximum Non-Medi-cal	**28**	**(164)**	**-136**	**(487%)**	**335**	**164**	**+171**	**+51%**		
INDIRECT BILLED HOURS (Represents 15% of Annual Goal for Billed Hours)											
MAA		99	102	+3	+3%	1183	102	-1081	-91%		
Quality Assurance		99	20	-79	-80%	1183	20	-1163	-98%		
	Subtotal	**197**	**122**	**-75**	**-38%**	**2366**	**122**	**-2244**	**-95%**	**2366**	5.2%
										15776	**6.9%**
	Medi-cal	**1203**	**759**	**-444**	**-37%**	**14435**	**759**	**-13676**	**-95%**		
	Maximum Non-Medi-cal	**112**	**(324)**	**-212**	**(190%)**	**1341**	**324**	**+1017**	**+76%**		
	GRAND TOTAL	**1315**	**1083**	**-232**	**-18%**	**15776**	**1083**	**-14693**	**-93%**		





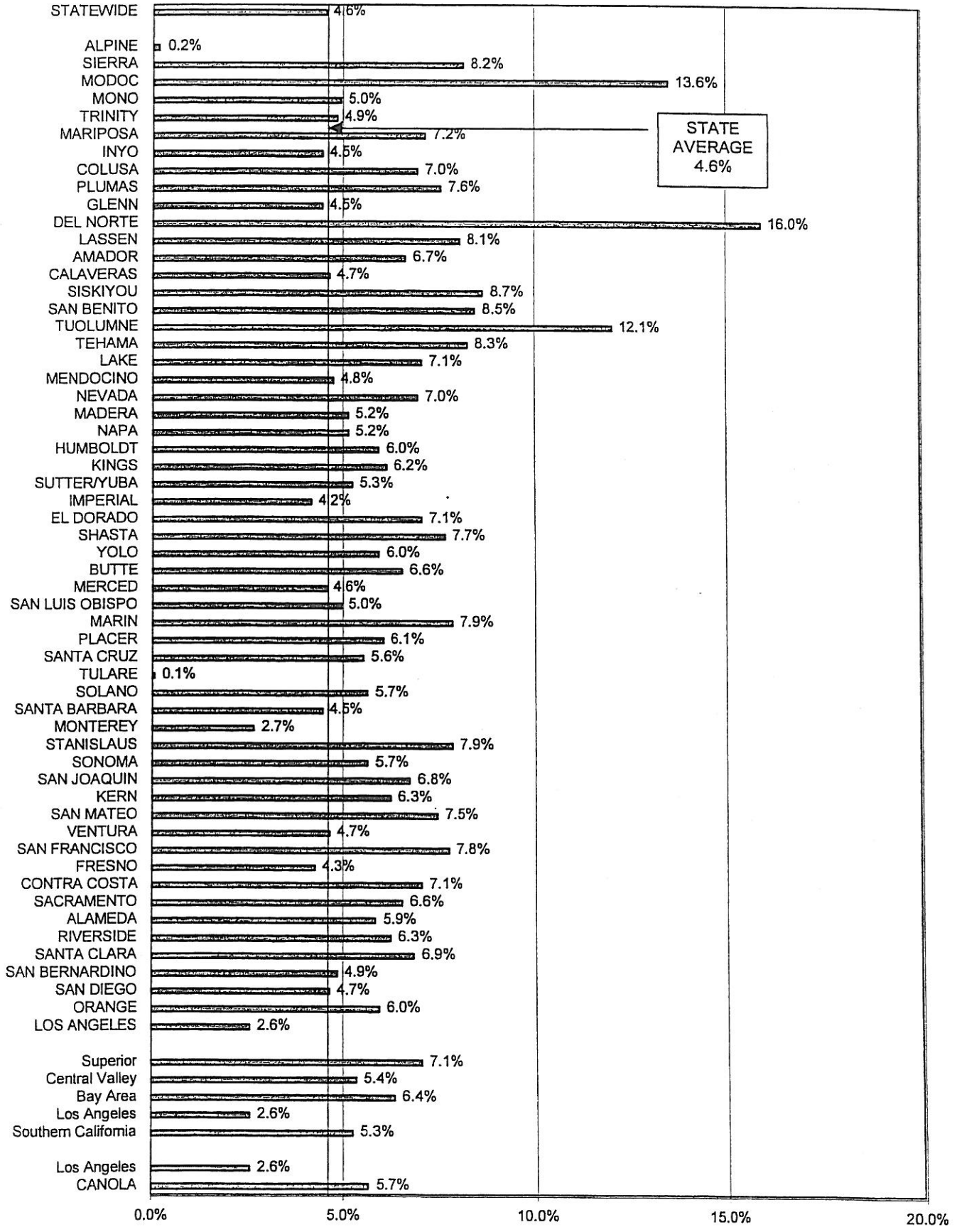




ATTACHMENT 2

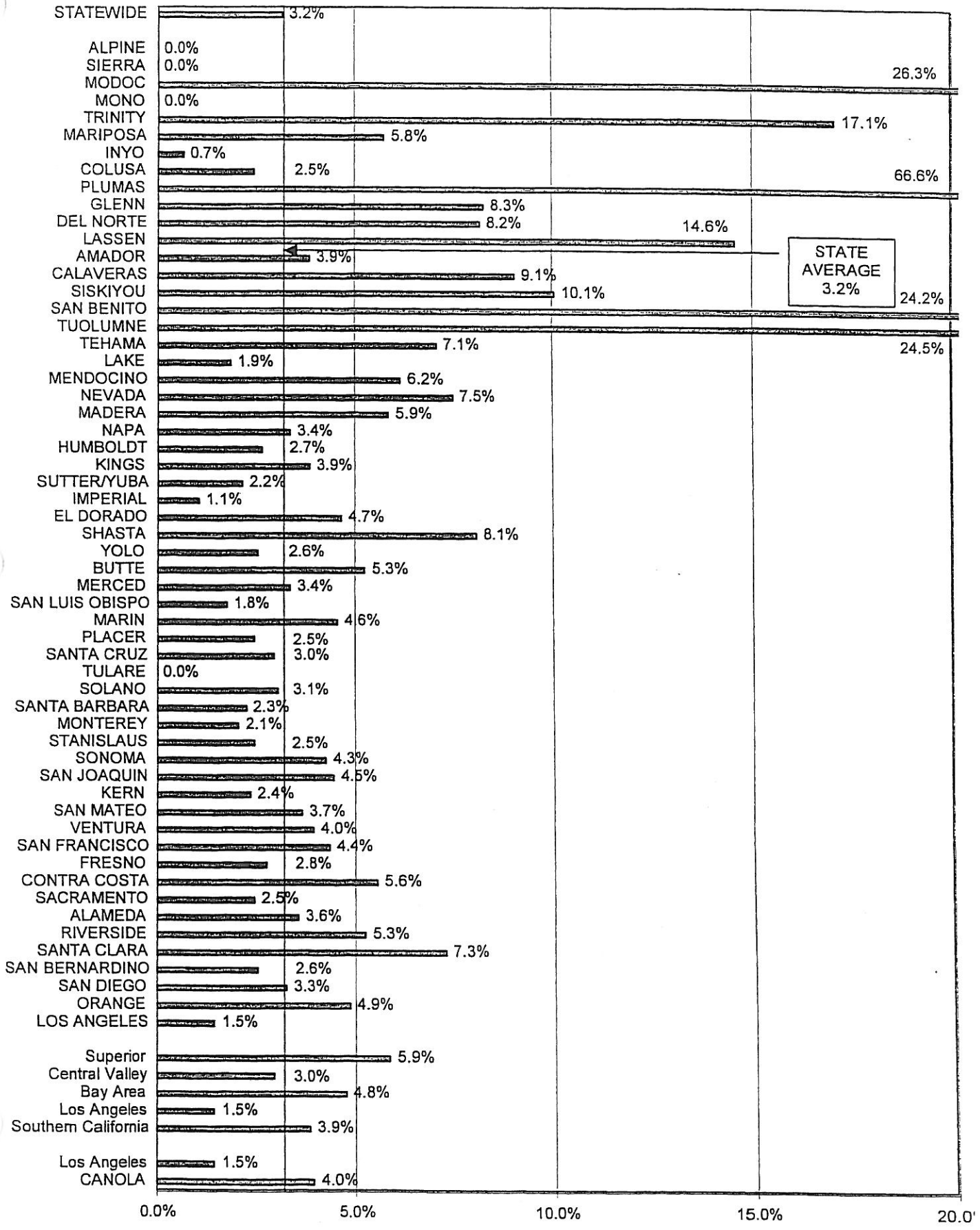
ALL RACE / ETHNIC GROUPS
PENETRATION RATE FOR MENTAL HEALTH SERVICES
BY COUNTY, SORTED BY TOTAL POPULATION
FOR FISCAL YEAR 1999-00

Attachment #2



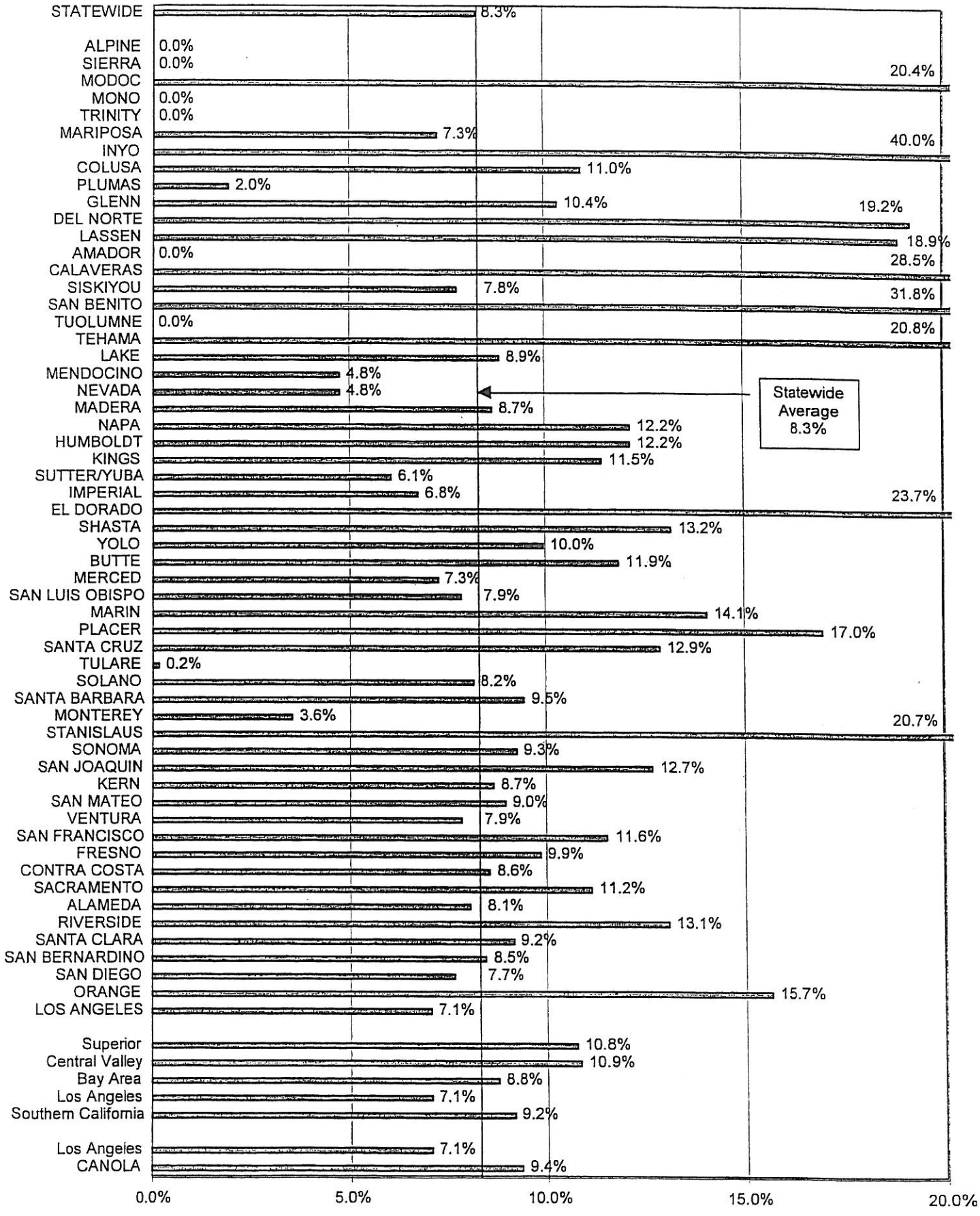
R1-6

RACE / ETHNIC GROUP: ASIAN OR PACIFIC ISLANDER
PENETRATION RATE FOR MENTAL HEALTH SERVICES
BY COUNTY, SORTED BY TOTAL POPULATION
FOR FISCAL YEAR 1999-00



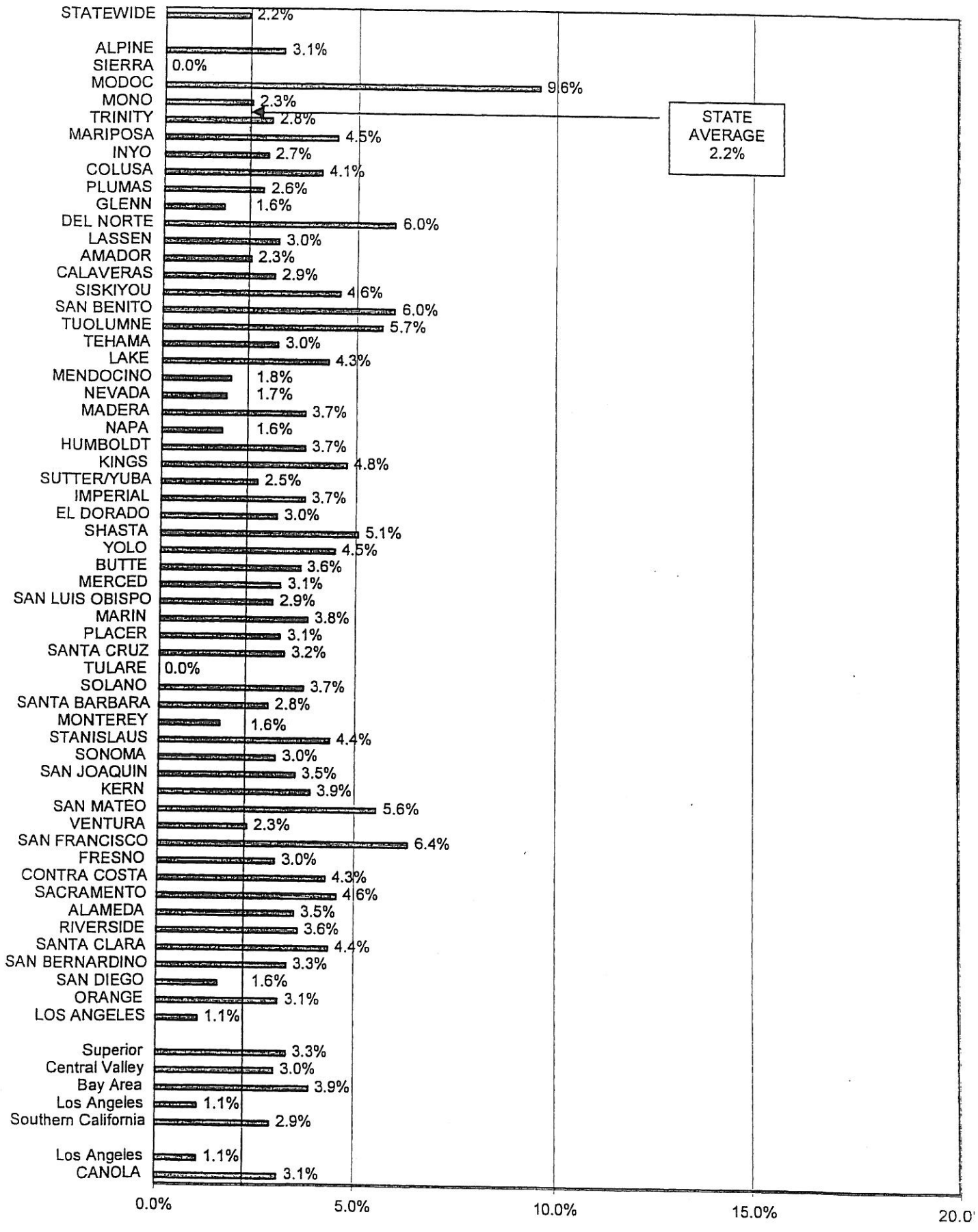
R1-7

RACE / ETHNIC GROUP: BLACK
PENETRATION RATE FOR MENTAL HEALTH SERVICES
BY COUNTY, SORTED BY TOTAL POPULATION
FOR FISCAL YEAR 1999-00

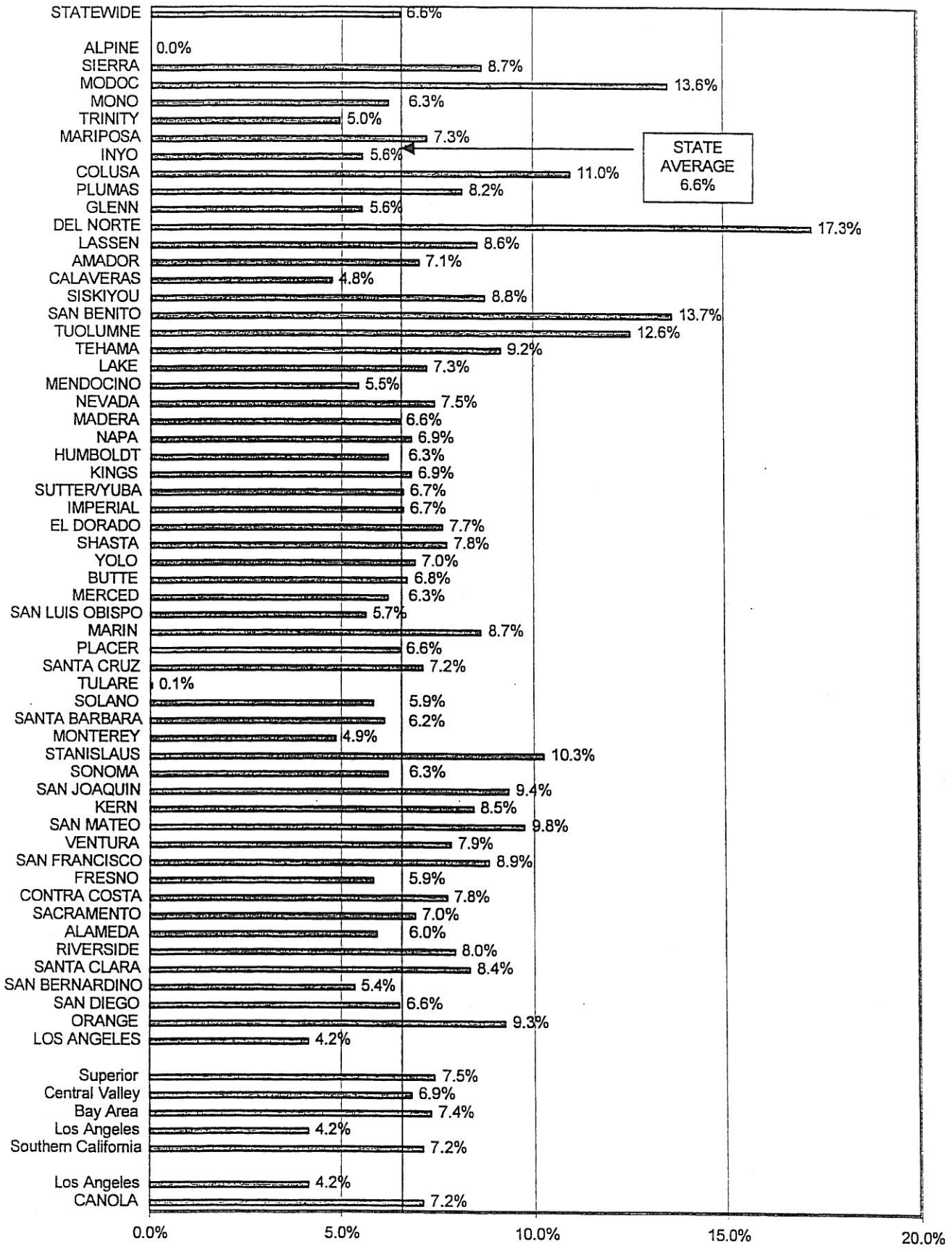


R1-8

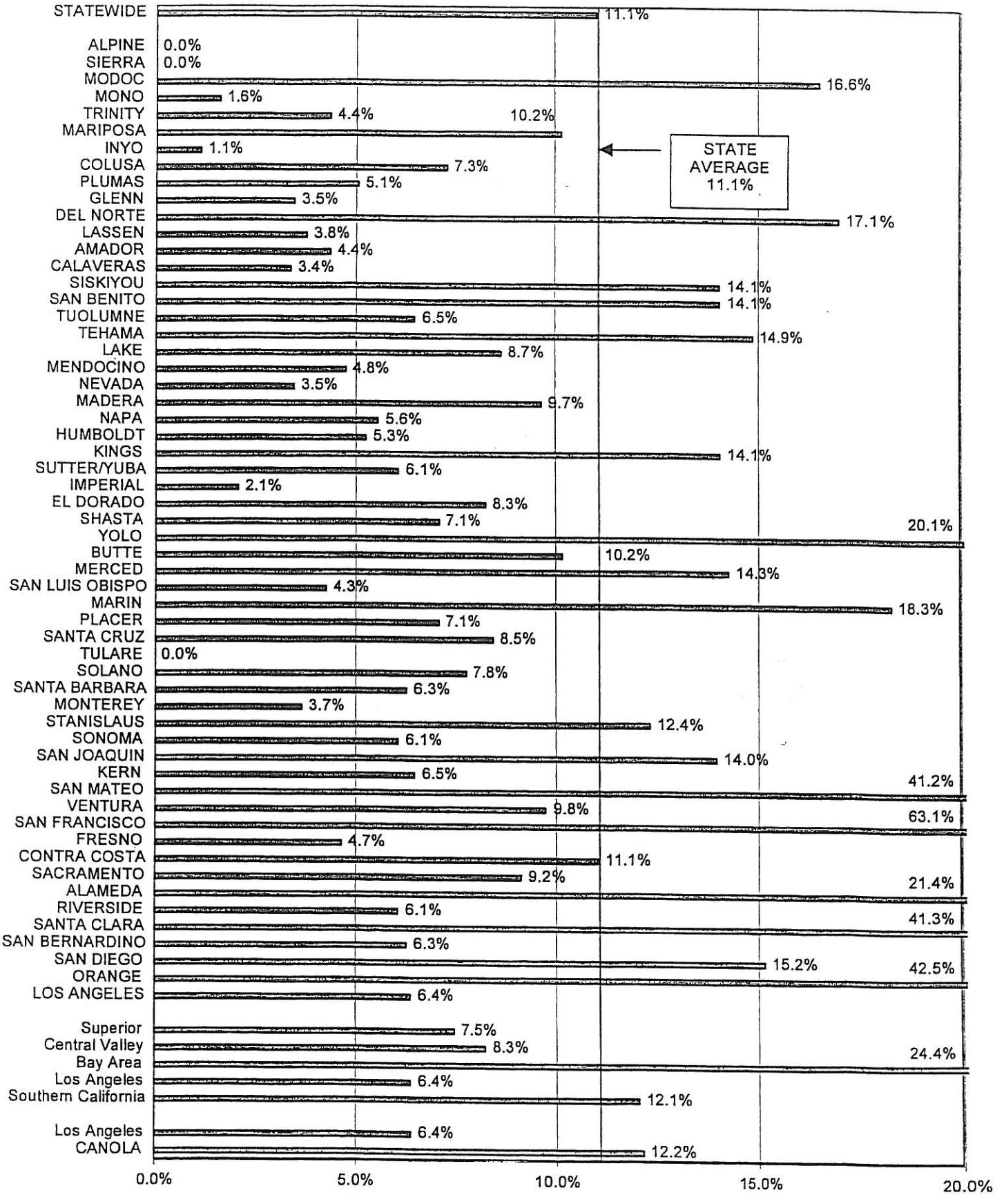
RACE / ETHNIC GROUP: HISPANIC
PENETRATION RATE FOR MENTAL HEALTH SERVICES
BY COUNTY, SORTED BY TOTAL POPULATION
FOR FISCAL YEAR 1999-00



RACE / ETHNIC GROUP: WHITE
PENETRATION RATE FOR MENTAL HEALTH SERVICES
BY COUNTY, SORTED BY TOTAL POPULATION
FOR FISCAL YEAR 1999-00



RACE / ETHNIC GROUP: OTHER
PENETRATION RATE FOR MENTAL HEALTH SERVICES
BY COUNTY, SORTED BY TOTAL POPULATION
FOR FISCAL YEAR 1999-00



R1-11

ATTACHMENT 3

Table 13. Medi-Cal beneficiaries with specialty mental health services in San Bernardino County during calendar year 2002, by region.

	Desert/ Big Bear		East Valley		Central Valley		West Valley	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Ethnicity								
White	3,375	69.8%	3,076	47.2%	915	29.5%	1,945	40.9%
Hispanic	668	13.8%	1,532	23.5%	1,119	36.1%	1,698	35.7%
Black	571	11.8%	1,538	23.6%	933	30.1%	766	16.1%
Asian/PI	43	0.9%	124	1.9%	43	1.4%	180	3.8%
Other/Unknown	180	3.7%	249	3.8%	87	2.8%	164	3.5%
	4,837	*100.0%*	*6,519*	*100.0%*	*3,097*	*100.0%*	*4,753*	*100.0%*
Age Group								
0-17	1,658	34.3%	2,037	31.2%	1,217	39.3%	1,662	35.0%
18-20	165	3.4%	237	3.6%	89	2.9%	179	3.8%
21-44	1,951	40.3%	2,597	39.8%	1,163	37.6%	1,884	39.6%
45-64	995	20.6%	1,531	23.5%	574	18.5%	919	19.3%
65+	68	1.4%	117	1.8%	54	1.7%	109	2.3%
	4,837	*100.0%*	*6,519*	*100.0%*	*3,097*	*100.0%*	*4,753*	*100.0%*
Sex								
Female	2,654	54.9%	3,502	53.7%	1,648	53.2%	2,596	54.6%
Male	2,177	45.0%	3,015	46.2%	1,447	46.7%	2,154	45.3%
Unknown	6	0.1%	2	0.0%	2	0.1%	3	0.1%
	4,837	*100.0%*	*6,519*	*100.0%*	*3,097*	*100.0%*	*4,753*	*100.0%*
Primary Diagnosis								
Mood Disorders	2,137	44.2%	3,023	46.4%	1,235	39.9%	2,257	47.5%
Schizophrenia/Psychotic Dis	910	18.8%	1,565	24.0%	614	19.8%	907	19.1%
Childhood & Adol. Dis	782	16.2%	1,035	15.9%	622	20.1%	872	18.3%
Anxiety Disorders	380	7.9%	428	6.6%	285	9.2%	394	8.3%
Adjustment Disorders	437	9.0%	251	3.9%	205	6.6%	212	4.5%
Other Diagnoses	191	3.9%	217	3.3%	136	4.4%	111	2.3%
	4,837	*100.0%*	*6,519*	*100.0%*	*3,097*	*100.0%*	*4,753*	*100.0%*
Primary Language								
English	4,572	94.5%	5,779	88.6%	2,716	87.7%	4,153	87.4%
Spanish	41	0.8%	204	3.1%	196	6.3%	269	5.7%
Asian/PI	12	0.2%	63	1.0%	28	0.9%	120	2.5%
Other/Unknown	212	4.4%	473	7.3%	157	5.1%	211	4.4%
	4,837	*100.0%*	*6,519*	*100.0%*	*3,097*	*100.0%*	*4,753*	*100.0%*

Source: County "INSYST" client/services database

Note: Region totals may be less than county-level totals since some clients had invalid zip codes

Prepared by Research and Evaluation (6/4/03)

ATTACHMENT 4

Attachment 4

Medi-Cal beneficiaries with **crisis** specialty mental health services in San Bernardino County during calendar year 2002, by region.

	Desert/ Big Bear		East Valley		Central Valley		West Valley	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Ethnicity								
White	591	69.8%	942	51.2%	298	34.4%	458	45.9%
Hispanic	111	13.1%	380	20.7%	266	30.7%	329	33.0%
Black	107	12.6%	425	23.1%	258	29.8%	156	15.6%
Asian/PI	6	0.7%	29	1.6%	15	1.7%	26	2.6%
Other/Unknown	32	3.8%	64	3.5%	30	3.5%	28	2.8%
	847	*100.0%*	*1,840*	*100.0%*	*867*	*100.0%*	*997*	*100.0%*
Age Group								
0-17	248	29.3%	359	19.5%	216	24.9%	208	20.9%
18-20	30	3.5%	102	5.5%	38	4.4%	65	6.5%
21-44	391	46.2%	937	50.9%	425	49.0%	555	55.7%
45-64	169	20.0%	413	22.4%	174	20.1%	155	15.5%
65+	9	1.1%	29	1.6%	14	1.6%	14	1.4%
	847	*100.0%*	*1,840*	*100.0%*	*867*	*100.0%*	*997*	*100.0%*
Sex								
Female	516	60.9%	1,018	55.3%	438	50.5%	524	52.6%
Male	331	39.1%	821	44.6%	428	49.4%	472	47.3%
Unknown	0	0.0%	1	0.1%	1	0.1%	1	0.1%
	847	*100.0%*	*1,840*	*100.0%*	*867*	*100.0%*	*997*	*100.0%*
Primary Diagnosis								
Mood Disorders	448	52.9%	961	52.2%	436	50.3%	515	51.7%
Schizophrenia/Psychotic Dis	201	23.7%	610	33.2%	265	30.6%	319	32.0%
Childhood & Adol. Dis	84	9.9%	101	5.5%	56	6.5%	60	6.0%
Anxiety Disorders	44	5.2%	61	3.3%	28	3.2%	45	4.5%
Adjustment Disorders	36	4.3%	40	2.2%	31	3.6%	20	2.0%
Other Diagnoses	34	4.0%	67	3.6%	51	5.9%	38	3.8%
	847	*100.0%*	*1,840*	*100.0%*	*867*	*100.0%*	*997*	*100.0%*
Primary Language								
English	812	95.9%	1,701	92.4%	799	92.2%	910	91.3%
Spanish	3	0.4%	26	1.4%	30	3.5%	43	4.3%
Asian/PI	1	0.1%	10	0.5%	5	0.6%	7	0.7%
Other/Unknown	31	3.7%	103	5.6%	33	3.8%	37	3.7%
	847	*100.0%*	*1,840*	*100.0%*	*867*	*100.0%*	*997*	*100.0%*

Source: County "INSYST" client/services database

Note: Region totals may be less than county-level totals since some clients had invalid zip codes

Prepared by Research and Evaluation (6/4/03)

ATTACHMENT 5

Table 15. Medi-Cal beneficiaries with crisis specialty mental health services in San Bernardino County during calendar year 2002, by region.

	Desert/ Big Bear		East Valley		Central Valley		West Valley	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Ethnicity								
White	591	69.8%	942	51.2%	298	34.4%	458	45.9%
Hispanic	111	13.1%	380	20.7%	266	30.7%	329	33.0%
Black	107	12.6%	425	23.1%	258	29.8%	156	15.6%
Asian/PI	6	0.7%	29	1.6%	15	1.7%	26	2.6%
Other/Unknown	32	3.8%	64	3.5%	30	3.5%	28	2.8%
	847	*100.0%*	*1,840*	*100.0%*	*867*	*100.0%*	*997*	*100.0%*
Age Group								
0-17	248	29.3%	359	19.5%	216	24.9%	208	20.9%
18-20	30	3.5%	102	5.5%	38	4.4%	65	6.5%
21-44	391	46.2%	937	50.9%	425	49.0%	555	55.7%
45-64	169	20.0%	413	22.4%	174	20.1%	155	15.5%
65+	9	1.1%	29	1.6%	14	1.6%	14	1.4%
	847	*100.0%*	*1,840*	*100.0%*	*867*	*100.0%*	*997*	*100.0%*
Sex								
Female	516	60.9%	1,018	55.3%	438	50.5%	524	52.6%
Male	331	39.1%	821	44.6%	428	49.4%	472	47.3%
Unknown	0	0.0%	1	0.1%	1	0.1%	1	0.1%
	847	*100.0%*	*1,840*	*100.0%*	*867*	*100.0%*	*997*	*100.0%*
Primary Diagnosis								
Mood Disorders	448	52.9%	961	52.2%	436	50.3%	515	51.7%
Schizophrenia/Psychotic Dis	201	23.7%	610	33.2%	265	30.6%	319	32.0%
Childhood & Adol. Dis	84	9.9%	101	5.5%	56	6.5%	60	6.0%
Anxiety Disorders	44	5.2%	61	3.3%	28	3.2%	45	4.5%
Adjustment Disorders	36	4.3%	40	2.2%	31	3.6%	20	2.0%
Other Diagnoses	34	4.0%	67	3.6%	51	5.9%	38	3.8%
	847	*100.0%*	*1,840*	*100.0%*	*867*	*100.0%*	*997*	*100.0%*
Primary Language								
English	812	95.9%	1,701	92.4%	799	92.2%	910	91.3%
Spanish	3	0.4%	26	1.4%	30	3.5%	43	4.3%
Asian/PI	1	0.1%	10	0.5%	5	0.6%	7	0.7%
Other/Unknown	31	3.7%	103	5.6%	33	3.8%	37	3.7%
	847	*100.0%*	*1,840*	*100.0%*	*867*	*100.0%*	*997*	*100.0%*

Source: County "INSYST" client/services database

Note: Region totals may be less than county-level totals since some clients had invalid zip codes

Prepared by Research and Evaluation (6/4/03)

ATTACHMENT 6

Table 17. Medi-Cal beneficiaries with day treatment / residential specialty mental health services in San Bernardino County during calendar year 2002, by region.

	Desert/ Big Bear		East Valley		Central Valley		West Valley	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Ethnicity								
White	32	57.1%	263	53.9%	42	45.7%	100	48.8%
Hispanic	13	23.2%	76	15.6%	22	23.9%	60	29.3%
Black	9	16.1%	118	24.2%	20	21.7%	33	16.1%
Asian/PI	1	1.8%	7	1.4%	2	2.2%	6	2.9%
Other/Unknown	1	1.8%	24	4.9%	6	6.5%	6	2.9%
	56	*100.0%*	*488*	*100.0%*	*92*	*100.0%*	*205*	*100.0%*
Age Group								
0-17	12	21.4%	58	11.9%	8	8.7%	10	4.9%
18-20	3	5.4%	28	5.7%	4	4.3%	12	5.9%
21-44	28	50.0%	254	52.0%	54	58.7%	125	61.0%
45-64	12	21.4%	144	29.5%	25	27.2%	55	26.8%
65+	1	1.8%	4	0.8%	1	1.1%	3	1.5%
	56	*100.0%*	*488*	*100.0%*	*92*	*100.0%*	*205*	*100.0%*
Sex								
Female	28	50.0%	240	49.2%	48	52.2%	80	39.0%
Male	28	50.0%	248	50.8%	44	47.8%	125	61.0%
Unknown	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	56	*100.0%*	*488*	*100.0%*	*92*	*100.0%*	*205*	*100.0%*
Primary Diagnosis								
Mood Disorders	24	42.9%	172	35.2%	29	31.5%	62	30.2%
Schizophrenia/Psychotic Dis	26	46.4%	271	55.5%	60	65.2%	131	63.9%
Childhood & Adol. Dis	3	5.4%	21	4.3%	1	1.1%	1	0.5%
Anxiety Disorders	0	0.0%	10	2.0%	1	1.1%	3	1.5%
Adjustment Disorders	2	3.6%	0	0.0%	0	0.0%	0	0.0%
Other Diagnoses	1	1.8%	14	2.9%	1	1.1%	8	3.9%
	56	*100.0%*	*488*	*100.0%*	*92*	*100.0%*	*205*	*100.0%*
Primary Language								
English	55	98.2%	446	91.4%	83	90.2%	183	89.3%
Spanish	0	0.0%	2	0.4%	2	2.2%	5	2.4%
Asian/PI	0	0.0%	2	0.4%	0	0.0%	1	0.5%
Other/Unknown	1	1.8%	38	7.8%	7	7.6%	16	7.8%
	56	*100.0%*	*488*	*100.0%*	*92*	*100.0%*	*205*	*100.0%*

Source: County "INSYST" client/services database

Note: Region totals may be less than county-level totals since some clients had invalid zip codes

Prepared by Research and Evaluation (6/4/03)

ATTACHMENT 7

Table 14. Medi-Cal beneficiaries with inpatient specialty mental health services in San Bernardino County during calendar year 2002, by region.

	Desert/ Big Bear		East Valley		Central Valley		West Valley	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Ethnicity								
White	301	70.3%	494	53.1%	129	34.9%	244	49.0%
Hispanic	50	11.7%	205	22.0%	116	31.4%	165	33.1%
Black	59	13.8%	188	20.2%	104	28.1%	59	11.8%
Asian/PI	1	0.2%	15	1.6%	8	2.2%	13	2.6%
Other/Unknown	17	4.0%	29	3.1%	13	3.5%	17	3.4%
	428	*100.0%*	*931*	*100.0%*	*370*	*100.0%*	*498*	*100.0%*
Age Group								
0-17	106	24.8%	169	18.2%	100	27.0%	94	18.9%
18-20	19	4.4%	65	7.0%	19	5.1%	41	8.2%
21-44	227	53.0%	483	51.9%	173	46.8%	275	55.2%
45-64	74	17.3%	206	22.1%	75	20.3%	84	16.9%
65+	2	0.5%	8	0.9%	3	0.8%	4	0.8%
	428	*100.0%*	*931*	*100.0%*	*370*	*100.0%*	*498*	*100.0%*
Sex								
Female	261	61.0%	491	52.7%	188	50.8%	250	50.2%
Male	165	38.6%	439	47.2%	181	48.9%	248	49.8%
Unknown	2	0.5%	1	0.1%	1	0.3%	0	0.0%
	428	*100.0%*	*931*	*100.0%*	*370*	*100.0%*	*498*	*100.0%*
Primary Diagnosis								
Mood Disorders	249	58.2%	477	51.2%	194	52.4%	249	50.0%
Schizophrenia/Psychotic Dis	132	30.8%	371	39.8%	127	34.3%	202	40.6%
Childhood & Adol. Dis	22	5.1%	40	4.3%	16	4.3%	20	4.0%
Anxiety Disorders	8	1.9%	9	1.0%	10	2.7%	7	1.4%
Adjustment Disorders	6	1.4%	5	0.5%	6	1.6%	4	0.8%
Other Diagnoses	11	2.6%	29	3.1%	17	4.6%	16	3.2%
	428	*100.0%*	*931*	*100.0%*	*370*	*100.0%*	*498*	*100.0%*
Primary Language								
English	417	97.4%	883	94.8%	350	11.3%	460	92.4%
Spanish	1	0.2%	14	1.5%	9	0.3%	19	3.8%
Asian/PI	0	0.0%	6	0.6%	4	0.1%	1	0.2%
Other/Unknown	10	2.3%	28	3.0%	7	0.2%	18	3.6%
	428	*100.0%*	*931*	*100.0%*	*370*	*11.9%*	*498*	*100.0%*

Source: County "INSYST" client/services database

Note: Region totals may be less than county-level totals since some clients had invalid zip codes

Prepared by Research and Evaluation (6/4/03)

ATTACHMENT 8

Attachment Attachment #8
From the desk of the Director

Dear staff,
Attached you will find a copy of the California Brief Multicultural Competency Scale (CBMCS). The instrument is a 21-item scale specifically developed to measure self-report multicultural competency of the mental health service providers, and it is part of a cultural competence-training curriculum. The scores of your responses will help the Cultural Competence Unit provide Behavioral Health's Staff with the Cultural Competence training needed.
If you want your score send to you we would need your name. We want to reassure you that the information obtained will be use only for training purposes and will not be part of your personnel record. Your supervisor will be provide with the group overall scores.

Please provide us with the following information:
Name (optional)_____ Age_____ Gender_____
Sexual Orientation_____
DBH Region_____
Clinic/ Program_____ Number or years with DBH_____
Number of years working in the mental Health field_____
Number of years working with multicultural clients_____

Race/Ethnicity

1. White American
2. Hispanic/Latino
3. African American
4. Asian American/Pacific Islander
5. Native American
6. Other

Country of Origin

1. Born and raised in the USA
2. Born and raised outside the USA

Language

1. English only
2. Bilingual. If bilingual in what language? _____

Job/Position

1. Clinical position Licensed_____non-licensed_____
2. Clerical and other non-clinical positions. Primary Job Function_____
3. Administration/ management position

Education In the USA

1. Ph.D.
2. Master Degree
3. Bachelor Degree
4. High School
5. Other

Education Outside the USA

1. PhD
2. Master Degree
3. Bachelor Degree
4. High School
5. Other

Below is a list of statements dealing with multicultural issues within a mental health context. Please indicate the degree to which you agree with each statement by circling the appropriate number.

Strongly Disagree

Agree Strongly

Disagree Agree

1. I am aware that being born a minority in this society brings with it certain 1 2 3 4
challenges that White people do not have to face.

2. I am aware of how my own values might affect my client. 1 2 3 4

3. I have an excellent ability to assess, accurately, the mental health needs of 1 2 3 4
persons with disabilities.

4. I am aware of institutional barriers that affect the client. 1 2 3 4

5. I have an excellent ability to assess, accurately, the mental health needs of 1 2 3 4
lesbians.

6. I have an excellent ability to assess, accurately, the mental health needs of 1 2 3 4
older adults.

7. I have an excellent ability to identify the strengths and weaknesses of 1 2 3 4
psychological tests in terms of their use with persons from different cultural, racial and/or ethnic backgrounds.

8. I am aware that counselors frequently impose their own cultural values upon 1 2 3 4
minority clients.

9. My communication skills are appropriate for my clients. 1 2 3 4

10. I am aware that being born a White person in this society carries with it certain 1 2 3 4 advantages.

11. I am aware of how my cultural background and experiences have influenced my 1 2 3 4
attitudes about psychological processes.

12. I have an excellent ability to critique multicultural research. 1 2 3 4

13. I have an excellent ability to assess, accurately, the mental health needs of men. 1 2 3 4

14. I am aware of institutional barriers that may inhibit minorities from using mental health services. 1 2 3 4

15. I can discuss, within a group, the differences among ethnic groups (e.g. low socioeconomic status (SES), Puerto Rican client vs. high SES Puerto Rican client). 1 2 3 4

16. I can identify my reactions that are based on stereotypical beliefs about different ethnic groups. 1 2 3 4

17. I can discuss research regarding mental health issues and culturally different populations. 1 2 3 4

18. I have an excellent ability to assess, accurately, the mental health needs of gay men. 1 2 3 4

19. I am knowledgeable of acculturation models for various ethnic minority groups. 1 2 3 4

20. I have an excellent ability to assess, accurately, the mental health needs of women. 1 2 3 4

21. I have an excellent ability to assess, accurately, the mental health needs of persons who come from very poor socioeconomic backgrounds. 1 2 3 4

ATTACHMENT 9

MHSIP Consumer Survey

This survey was developed through a collaborative effort of consumers, the Mental Health Statistics Improvement Program (MHSIP) community, and the Center for Mental Health Services.

INSTRUCTIONS: This survey will help us to improve our mental health services for you. Your answers will be kept confidential and will only be used to evaluate and improve the services here. Please indicate your agreement or disagreement with each of the statements below. Fill in the circle that best represents your opinion.

Client ID Number

0 1 2 3 4 5 6 7 8 9 A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

County

0 1 2 3 4 5 6 7 8 9

Link Date

0 1 2 3 4 5 6 7 8 9

	Strongly Agree 5	Agree 4	I am Neutral 3	Disagree 2	Strongly Disagree 1	Not Applicable 0
I like the services that I received here.	○	○	○	○	○	○
If I had other choices, I would still choose to get services from this agency.	○	○	○	○	○	○
I would recommend this agency to a friend or family member.	○	○	○	○	○	○
The location of services was convenient *(parking, public transportation, distance, etc.)*	○	○	○	○	○	○
Staff were willing to help as often as I felt it was necessary.	○	○	○	○	○	○
Staff returned my calls within 24 hours.	○	○	○	○	○	○
Services were available at times that were good for me.	○	○	○	○	○	○
I was able to get all the services I thought I needed.	○	○	○	○	○	○
Staff here believed that I could grow, change, and recover.	○	○	○	○	○	○
I felt safe to raise questions or complain.	○	○	○	○	○	○
Staff told me what side effects to watch for.	○	○	○	○	○	○
Staff respected my wishes about who is, and is not, to be given information about my treatment.	○	○	○	○	○	○

Please Continue on Page 2

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do not make any marks below this line

	Strongly Agree 5	Agree 4	I am Neutral 3	Disagree 2	Strongly Disagree 1	Not Applicable 0
3 aff were sensitive to my cultural/ethnic ckground.	○	○	○	○	○	○
4. Staff helped me so that I could manage my life and recover.	○	○	○	○	○	○
5. I felt that I was treated with respect by the receptionist.	○	○	○	○	○	○
6. I felt comfortable asking questions about my treatment and medication.	○	○	○	○	○	○
7. Staff and I worked together to plan my treatment.	○	○	○	○	○	○
8. I, not staff, decided my treatment goals.	○	○	○	○	○	○
9. I was given written information that I could understand.	○	○	○	○	○	○

As a Direct Result of Services I Received:

0. I deal more effectively with daily problems.	○	○	○	○	○	○
1. I am better able to control my life.	○	○	○	○	○	○
2 ' am better able to deal with crisis.	○	○	○	○	○	○
am getting along better with my family.	○	○	○	○	○	○
4. I do better in social situations.	○	○	○	○	○	○
5. I do better in school and/or work.	○	○	○	○	○	○
6. My symptoms are not bothering me as much.	○	○	○	○	○	○

27. How did you become involved with this program?

○ I decided to come in on my own.
○ Someone else recommended I come in.
○ I came in against my will.

28. What would you like to see changed about this program? (Write comments in box below)

2. o you currently attend self-help?

○ es ○ Not Available ○ No

30. If YES, how often do you participate?

○ Daily ○ Weekly ○ Monthly ○ Occasionally

do not make any marks below this line

Form Linking Number

20830

ATTACHMENT 10

58779

San Bernardino County, Department of Behavioral Health

Threshold Language Survey

Client ID: | | | | | | | |

Clinic Number: | | | | | |

Date Completed: | | | / | | | / | | | | |

month day year

(Please fill in the appropriate circles)

1. Did you receive mental health services in your preferred language?
   O Always O Sometimes O Never

   Did you receive written information in your preferred language?

   O Yes O No

1. ¿Recibió servicios de salud mental en su idioma preferido?
   O Siempre O Algunas Veces O Nunca

2. ¿Recibió informacíon por escrito en su idioma preferido?

   O Sí O No

ATTACHMENT 11

Table 1. Characteristics of county mental health clients, 1992-2002 [n=69,685].

	Drop-Outs *n=9,525*	All Others *n=60,160*	Pearson Chi-Square statistic, df and signif.		
Contract Clinic	24.2%	22.1%	21.3	d.f.1	(p=0.000)
Lowest quartile, % of clients that are new	20.0%	25.9%			
Second quartile of new clients per year	19.1%	26.0%			
Third quartile	23.3%	25.1%			
Highest quartile	37.6%	23.0%	993.5	d.f.3	(p=0.000)
Lowest quartile, average clients per staff	20.2%	25.9%			
Second quartile, ave. clients/staff per year	19.9%	26.9%			
Third quartile	25.8%	24.6%			
Highest quartile	34.1%	22.6%	707.9	d.f.3	(p=0.000)
Lowest quartile, per capita income	20.7%	25.3%			
Second quartile	22.2%	24.0%			
Third quartile	30.7%	23.7%			
Highest quartile	26.4%	27.5%	269.8	d.f.3	(p=0.000)
East Valley Region	31.1%	32.3%			
Central Valley Region	12.2%	15.4%			
West Valley Region	18.6%	28.7%			
Desert/Mountain Region	38.1%	23.6%	1,045.5	d.f.3	(p=0.000)
Client's address unknown or out-of-county	12.3%	6.7%	371.5	d.f.1	(p=0.000)
Female (male ref.)	51.5%	53.2%	9.9	d.f.1	(p=0.002)
Youth (<18)	36.2%	35.8%			
Adults	61.1%	61.7%			
Seniors (60+)	2.7%	2.5%	1.6	d.f.2	(p=0.447)
White (ref.)	53.1%	52.6%			
Black	16.0%	16.4%			
Latino	25.5%	25.5%			
Other race/ethnicity	5.4%	5.5%	1.6	d.f.3	(p=.656)
Married	14.5%	13.1%	12.3	d.f.1	(p=0.000)
Schizophrenia/Bipolar/Major Depression	19.0%	41.3%			
Other depression / anxiety disorders	31.2%	28.2%			
ADHD / Other childhood disorders	12.8%	16.3%			
Other diagnoses	37.0%	14.3%	3,595.0	d.f.3	(p=0.000)
Referred from another agency/provider	16.7%	21.9%	131.6	d.f.1	(p=0.000)
Primary language of English	87.9%	88.2%	0.8	d.f.1	(p=0.372)
GAF between 1 and 40	14.9%	26.0%	550.8	d.f.1	(p=0.000)
Medi-Cal beneficiary	61.4%	66.5%	94.9	d.f.1	(p=0.000)
Prior mental health treatment	9.5%	19.1%	524.0	d.f.1	(p=0.000)

Table 2. Likelihood of dropping out of mental health services, 1992-2002 [n=69,685].

	Model 1 Environment Pseudo R2=0.0351	**Model 2** Model 1 + Demographics Pseudo R2=0.0431	**Model 3** Model 2+ Clinical Pseudo R2=0.0991	95% Confidence Interval
Time (year dummies)				
Contract clinic (y/n)	0.93*	1.02	0.88***	(0.82, 0.94)
Ave clients/staff(quartiles)	1.11***	1.11***	1.06***	(1.04, 1.09)
Ratio of new clients(quartiles)	1.16***	1.16***	1.13***	(1.10, 1.16)
Central Valley (East Valley is ref.)	0.86***	0.80***	0.77***	(0.71, 0.83)
West Valley	0.79***	0.77***	0.76***	(0.71, 0.81)
Desert/Mountain	1.60***	1.60***	1.49***	(1.39, 1.59)
Unknown/Out-of-County address	1.97***	1.96***	1.90***	(1.75, 2.06)
Per capita income quartiles	0.96**	0.97**	0.98*	(0.95, 1.00)
Black (White is reference)		1.18**	1.26***	(1.18, 1.35)
Latino		1.24***	1.16***	(1.10, 1.24)
Other race/ethnicity		1.00	1.05	(0.95, 1.17)
Female		1.00	0.97	(0.93, 1.02)
Age		.99***	1.00	(1.00, 1.00)
Married		1.16***	1.08*	(1.00, 1.16)
Referred by other provider		0.69***	0.70***	(0.66, 0.74)
Preferred language not English		1.11**	1.10*	(1.02, 1.18)
Medi-Cal eligible		0.76***	0.80***	(0.76, 0.84)
GAF score 1 to 40			0.62***	(0.59, 0.67)
Depression/Anxiety (SMI is ref.)			2.08***	(1.95, 2.22)
ADHD/Other Child			1.64***	(1.50, 1.80)
Other diagnoses			4.51***	(4.21, 4.82)
Prior services			0.59***	(0.55, 0.64)

* significant at the p=0.05 level, ** signficant at the p=0.01 level, *** significant at the p=0.001 level.

Model 1: Chi-Square(18) = 1953.23, Log likelihood= -26,821.
Model 2: Chi-Square(27) = 2,398, Log likelihood= -26,598.
Model 3: Chi-Square(32) = 5510, Log likelihood= -25,042.

Table 3. Characteristics of minority clients, 1992-2002 [n=29,120].

* note, quartiles based on total population	Latino			Black		
	Drop-outs *n=2,432*	All Other *n=15,317*		Drop-outs *n=1,519*	All Other *n=9,852*	
Contract Clinic	15%	14%		12%	11%	
Lowest quartile, % of clients that are new	25	30		24	28	
Second quartile of new clients per year	23	28		24	29	
Third quartile	25	24		24	24	
Highest quartile	27	17	***	28	19	***
Lowest quartile, average clients per staff	23	28		19	22	
Second quartile, ave. clients/staff per year	21	29		23	29	
Third quartile	27	24		28	28	
Highest quartile	29	18	***	29	21	***
Lowest quartile, per capita income	31	34		33	37	
Second quartile	24	26		23	25	
Third quartile	25	20		20	18	
Highest quartile	21	21	***	23	20	***
East Valley Region	32	31		40	38	
Central Valley Region	19	21		21	25	
West Valley Region	27	37		18	25	
Desert/Mountain Region	22	12	***	21	12	***
Client's address unknown or out-of-county	10	5	***	13	6	***
Female (male ref.)	51	53	*	50	52	
Youth (<18)	43	42		46	42	
Adults	55	55		53	57	
Seniors (60+)	2	2		1	1	**
Married	17	15	**	8	8	
Schizophrenia/Bipolar/Major Depression	17	36		22	43	
Other depression / anxiety disorders	32	32		27	23	
ADHD / Other childhood disorders	14	18		20	23	
Other diagnoses	37	15	***	32	12	***
Referred from another agency/provider	15	21	***	16	20	**
Primary language of English	79	79		95	95	
GAF between 1 and 40	12	22	***	18	29	***
Medi-Cal beneficiary	65	68	**	74	77	*
Prior mental health treatment	9	17	***	11	20	***

* significant at the p=0.05 level, ** signficant at the p=0.01 level, *** significant at the p=0.001 le

ATTACHMENT 12

INTERPRETER SERVICES

Department of Behavioral Health
County Of San Bernardino

ISSUE

Recent expenditures on Interpreter Services have been brought forward due to excessive billings to Outside Interpreter Service Agencies. The purpose of this analysis is to address the Department's Interpreter Service practices, budget impact, quality of care issues, and to provide recommendations based on the findings.

BACKGROUND

As a nation, the United States continues to grow in diversity; our face, voice, and beliefs are forever changing. Despite the pace at which change in the healthcare marketplace is occurring, in many ways, the Nation's health delivery systems have not kept pace with our growing diversity. A significant disconnect has arisen between health care need and the availability and accessibility of relevant, culturally competent care for people who need it. The table below illustrates the ethnic breakdown of San Bernardino County and California (2000 census). This table indicates that Latino residents in San Bernardino County are higher than the overall percentage of California.

Ethnic Breakdown 2000 Census (Table A)

Location	White	Black/African American	American Indian/Alaska Native	Asian	Pacific Islander	Hispanics
California	59.5%	6.7%	1%	10.9%	.3%	32.4%
San Bernardino	62.6%	8.5%	1.1%	5.1%	.3%	34.6%

In the delivery of mental health and alcohol and drug services cultural issues and communication between consumer and provider are a critical part of the services. We realize that, while it is desirable that each mental health and alcohol and drug provider serves all clients in the client's first language, this is not always possible. According to the 2000 Census data 34% of San Bernardino County's residents speak a language other than English. The chart below shows the percentages of San Bernardino County, California, and the United States.

Language Other than English (Table B)

Location	Year	Percentage
United States	2000	17.5%
California	2000	39.3%
San Bernardino County	2000	34%

In addition, San Bernardino County has a higher population density of Spanish speakers (27.7%) than California and the United States. Therefore, establishing Spanish as our threshold language. It is essential to find proper ways of providing quality care to limited English speaking consumers.

Spanish Spoken at Home – Census 2000 (Table C)

Location	Year	Percentage
United States	2001	10.8%
California	2001	26.4%
San Bernardino County	2001	27.7%

Very few mental health and alcohol and drug providers are bilingual/bicultural, much less multilingual, and mental health and alcohol and drug professionals are seldom fluent in all languages of all their clients. The shortage of bilingual therapist is nationwide; therefore, the next best thing to a mental health and alcohol and drug provider skilled in the client's first language is a skilled interpreter. A skilled mental health interpreter is not just a bilingual person, but also a person who has knowledge and skills specific to the task of facilitating communication between clients and providers in the field of mental health and alcohol and drug.

ANALYSIS

In addition to our demographics, the Dymally-Alatorre Bilingual Services Act (DABSA), California Government Code Sections 7290-7299.8, requires that governmental agencies directly involved in the delivery of information or the administering of services to the public, provide services to non-English-speaking persons.

DBH has made efforts to comply with DABSA and Cultural Competence mandates placed upon the counties by the State Department of Mental Health to provide culturally and linguistically competent services to our consumers. DBH has hired bilingual staff, but many times the bilingual staff does not possess skills needed to be able to interpret. Although the County Of San Bernardino provides minimal testing for bilingual staff, this examination does not test staffs' level of fluency and understanding of cultural backgrounds. Another action taken in order to comply with DABSA was to develop contracts with outside agencies to provide interpretation services for our consumers. Although we have been able to provide services, DBH has incurred high costs and these costs continue to rise. Recently a combined contract was done through the county's Human Services System in an attempt to capture all costs of agencies required to comply with DABSA.

Although, we use outside contract agencies for interpreter services, we are concern with the quality of care that is provided to our consumers by using outside interpreter services. As mentioned before, a skilled mental health interpreter is not just a bilingual person, but also a person who has knowledge and skills specific to the task of facilitating communication between clients and providers in the field of mental health and alcohol and drug services. The major concern with contract agencies is the lack of actual training, knowledge of the mental health and alcohol & drug field and cultural competence issues. Most of these agencies lack the following ***key elements***:

- ❖ The interpreter must be culturally competent in all cultures he or she interprets for
- ❖ The interpreter must understand the medical and ethical dilemmas in mental health services
- ❖ The interpreter must be able to apply the ethics and professional rules to mental health care interpreting situations
- ❖ The interpreter must be skilled in facilitating communication between patient and provider without becoming a barrier to building a treatment relationship
- ❖ The interpreter must be familiar with the mental health setting and mental health system
- ❖ The interpreter must be familiar with vocabulary specific to mental health services

We are complying with state and federal mandates by using outside interpreter services, but the need to evaluate the quality of care being provided to our consumers through these agencies is being addressed.

The table below indicates expenditures for fiscal year 01 / 02 and the first six months of 02 / 03. It was found that DBH expenditures for six months were almost the same as what was spent for a full year (01 / 02).

(Table D)

Year	Amount
Fiscal Year 01/02	$95,822.73
Fiscal Year 02/03 (July-December)	$91,402.73

The chart below illustrates the type of service used for FY 01 / 02 and 02 / 03 (6 months), the total for each year and a Grand Total for both fiscal years by languages. It was identified that Spanish language is the most frequently used followed by Vietnamese and Sign Language.

(Table E)

Type OF Service	FY	Total	Grand Total FY 01 / 02 & 02 / 03
Spanish	01/02	$53,037.31	$109,507.37
	02/03	$56,470.06	
Vietnamese	01/02	$11,673.14	$23,346.56
	02/03	$11,673.42	
Phone Interpretation	01/02	$1,293.95	$1,305.87
(not specified)	02/03	$11.92	
Phone Cambodian	01/02	$47.91	$273.25
	02/03	$225.34	
Cambodian	01/02	$6,753.92	$9,703.81
	02/03	$2,949.89	
Sign Interpretation	01/02	$18,060.00	$37,236.76
	02/03	$19,176.76	
Laotian	01/02	$920.88	$1,024.48
	02/03	$103.60	

Farsi	01/02	$467.65	$1,000.53
	02/03	$532.88	
Phone Farsi	01/02	$22.72	$22.72
Tongan	01/02	$754.40	$866.16
	02/03	$111.76	
Trigrinian	01/02	$975.22	$975.22
Romanian	01/02	$1,119.20	$1,119.20
Philipino	01/02	$121.12	$121.12
Russian	01/02	$111.52	$111.52
Phone Russian	01/02	$9.71	$9.71
Portuguese	01/02	$223.36	$223.36
Arabic	01/02	$230.72	$230.72
Hmong	02/03	$147.10	$147.10
GRAND TOTAL	**01/02**	**$95,822.73**	**$187,225.46**
	02/03	**$91,402.73**	

* NOTE: See Attachment A

QUESTIONNAIRE

A questionnaire was sent to clinics that frequently used outside interpreter services. The questionnaire helped identify the number of bilingual staff, language, level and pay status. In addition, we gathered information on procedures that clinics use in obtaining outside interpreter services. It was also found the type of treatment provided by Outside Interpreter service agencies. The questionnaire also helped establish the most common languages clinics/programs use when accessing outside interpreter services. Other key information gathered was the length of time clinics used outside interpreter services with clients.

BILINGUAL STAFF

It was found that the Human Resources Master Bilingual list does not include all DBH staff. In order to develop a complete list of bilingual staff a telephone survey was conducted. Based on the telephone survey, a current list of DBH bilingual staff (Spanish and Vietnamese) by region and by clinic has been developed (see attachment B). In addition, we found out that not all bilingual pay employees are used to interpret and some bilingual employees that are not being paid are used to interpret.

Another valuable piece of information that would be interesting to find out is if bilingual clinical staff has the correct caseload. In other words, are they being use to see bilingual/monolingual clients only or do they see English speaking clients also. This would require another study.

The table below illustrates the percentage of **Latinos** accessing DBH clinics by region for the Month of February 2003, the number of bilingual pay and no pay staff, region population info, and the expenses incurred by each clinic using outside contract agencies for FY 01 / 02 and 02 / 03 (June-Dec). This table helps to identify the need of bilingual staff by consumer demand, region/clinic, and costs incurred.

(Table F)

Region	Total Region Pop.	Total Region Latino Pop. – (%)	Clinic	Total # of Latinos Accessing Clinics 2/03	Total # of Clients Accessing Clinics 2/03	% of Latinos Accessing Clinic for 2/03	DBH Pay Staff	DBH No Pay	Outside Contract agency Expense 01/02
			Access				2	1	$10,176.63
East	394,480	141,537 (36%)	Boys and Girls Club	7	26	26.9%			
			CalWorks San Bdno.	49	130	37.7%	2	1	
			Casa Ramona	70	110	63.7%	7	1	
			CID	116	308	24.1%	1		$ 1,573.00
			HAS – D Street	96	364	26.4%	2		
			Discovery	104	432	24.0%	3		
			Phoenix	323	1328	24.3%	7	1	$ 141.20
West	653,198	292,486 (45%)	CalWorks Ontario	109	190	57.4%	6	2	
			Chino	116	308	37.6%	4		$ 7,369.92
			Rancho Cucamonga	156	517	30.2%	6		$ 334.88
			Ujima	149	408	36.5%	3		$ 2, 006.04
			Upland	274	831	32.9%	4	1	$ 21,073.44
			Vista	281	638	44.1%	3		$ 13,758.52
Central	170,479	91,374 (53%)	Mesa	405	1279	31.0%	5	2	$29,986.98
			HAS – Rialto	23	82	28.0%	2		
			Nueva Vida	174	318	54.7%	5		$ 3,902.07
Desert	280,143	72,753 (26%)	Barstow	80	379	21.1%	3		
			CalWorks Barstow	10	51	19.7%	1		
			CalWorks Hesperia	49	181	27.2%			
			CalWorks Morongo	9	63	14.3%			
			Hesperia	19	176	11.4%			
			Lucerne Valley	6	88	6.8%			
			Victor Valley	200	1192	16.8%	5	1	$ 7,899.42
ADS			JJOP	48	164	29.3%	3	1	

* *$11,279.27 was spent by other offices such as COS, Conrep, etc.*

The table below illustrates the percentage of **Vietnamese** accessing DBH clinics by region for the Month of February 2003, the number of bilingual pay and no pay staff, region population, and the expenses incurred by each clinic using outside contract agencies for FY 01 / 02 and 02 / 03 (June-Dec). This table helps to identify the need of bilingual staff by consumer demand, region/clinic, and costs incurred.

(Table G)

Region	Total Region Pop.	Total Region Latino Pop. – (%)	Clinic	Total # of Vietnamese Accessing Clinics 2/03	Total # of Clients Accessing Clinics 2/03	% of Vietnamese Accessing Clinic for 2/03	DBH Pay Staff	DBH No Pay	Outside Contract agency Expense 01/02
West	653,198	5,873 (.1%)	Upland	76	831	9.1%		2 – 1 PSE leaving May 03	$15,379.08
East	394,480	3,996 (.1%)	Phoenix	622	1328	1.4%		*1	$2,084.48
Central	170,479	646 (.1%)	Mesa	9	1279	.7%		*1	$330.72

* *Medical Doctor*

FINDINGS

After researching the use of interpreter services data, the following was found:

- Clinics/Programs increased their use of outside interpreter services.
- Languages used the most are Spanish, Vietnamese and Sign.
- Clinics do not have a standard approval method for authorizing the use of outside interpreter services.
- Clinics do not have standard and clear procedures of when to utilize outside interpreter services.
- DBH has SPM 9-1.47 (Appendix D) issued in 11/99 on Satisfying Consumer Language Needs at Outpatient Clinics that does not address approval process and or using clinic and/or regional bilingual staff.
- Staff believes that there is extra money for interpreter services and therefore, do not consider alternatives before using outside interpreter services.
- The ACCESS unit is the highest user for Phone Spanish outside interpreter services because they do not have enough bilingual staff or they are not using their bilingual staff to their fullest.
- Some clinics/programs will not use bilingual clerical staff to interpret due to phone coverage.
- Clinics use interpreter services for consumer assessment, on-going med support and individual counseling, group, case management visits, and collateral services.
- Outside Interpreter services used for treatment last from one visit to 2 to 3 services a week ranging from 3 to 6 months.

RECOMMENDATIONS

Based on the information collected the following two recommendations are provided in an attempt to better our current interpreter service practices, to reduce cost of outside interpreter services, and to increase quality of care provided to consumers.

❖ INTERPRETER POOL

Develop a bilingual staff pool whose main duties are to serve as interpreters for clinics/programs and to translate materials. Hire five bilingual pay staff with the following distribution: 3 staff members to be bilingual in Spanish, 1 bilingual Vietnamese and 1 bilingual Sign Language. In order to accomplish this the following is required:

- Create a pool of 5 bilingual/bicultural interpreter staff whom are proficient in Spanish, Vietnamese and Sign
  - Select current staff that have experience translating
  - Redirect resources from Outside Interpreter Services to hire new clerical positions
  - Verify that interpreter pool staff receive bilingual pay
- Develop training for interpreter pool staff to address key elements for skilled interpreters
- Develop policy and procedure specifying the use of interpreter pool
- Train staff regarding the use of the interpreter pool and provide training on providing interpretation services.
- Redirect some staff to high used areas/clinics identified before to assist with demand.
- One of the main tasks of the interpreter pool staff will be to train current DBH staff that already provides interpreting services.

BUDGET/COST:

The current contract for Interpretation and Translation Services for DBH is $200,000 a year. The proposal is to allocate the interpretation and translation services funds and convert them into salaries for bilingual pay staff positions. Estimated allocation of funds is as follows:

(Table H)

Position	Estimated Yearly Salary	No. of Positions	Total Allocation Needed	Total
Allocation				$200,000.00
Clerk II	*$32,650.00	4	$130,600.00	
Clerk III	*$36,851.00	1	$36,851.00	
Total		**5**		-$167,451.00
Balance				$32,549.00
Outside Interpreters (for other languages not identified above)			$25,000.00	-$25,000.00
Total Savings				$7,549.00

*Numbers obtained from Al Evans.

DBH will increase the quality of care to our ethnically diverse consumers.

❖ **REDIRECT STAFF AND HIRE BILINGUAL STAFF**

- Place current bilingual staff in programs with greatest need of interpreter services (i.e. Mesa, Access Unit, and Upland Clinic)

Suggested changes:

- Currently Phoenix has three Bilingual Clinical Therapists and five bilingual clerks. Their number of Latinos accessing the clinic for the month of February 2003 was 24.3%, which is lower than Mesa's at 31.0% that has a part time bilingual clinician and four bilingual clerks. It is proposed to trade a clinical therapist from Mesa with a Bilingual Therapist from Phoenix. It is also proposed to trade a clerk from Mesa with a bilingual clerk from Casa Ramona. Casa Ramona has the highest access of Latinos to their clinic at 63.7%, but most of their service providers are bilingual and therefore, do not need bilingual clerks to interpret since clinicians and other service providers are providing their services in Spanish.
- Upland and CCICMS have a similar situation like Phoenix and Mesa and it is proposed to trade a clinician from Upland with a bilingual CCICMS clinician. Upland will also need another bilingual clerk. A trade can be done with Casa Ramona.
- Vista and Nueva Vida can also benefit by trading a clerk position with a bilingual clerk from Hospital Aftercare Central Region, Teamhouse, and Calworks.

(Table I)

Clinic in Need	Total #of Latinos Accessing Clinics 2/03	Total # of Clients Accessing Clinics 2/03	% of Latinos Accessing Clinic	Position Needed	From	To
Access				2 Bilingual Clerk	Payroll CalWorks	Access
Mesa	405	1279	31%	1 Bilingual CT 1 Bilingual Clerk	Phoenix Casa Ramona	Mesa Mesa
Upland	274	831	32.9%	1 Bilingual CT 1 Bilingual Clerk	CCICMS or Compliance Casa Ramona	Upland Upland
Vista	281	638	44.1%	1 Bilingual Clerk	ADS/Admin	Vista
Chino	116	308	37.6%	1 Bilingual Clerk	Teamhouse	Chino
Victor Valley	200	1192	16.8%	1 Bilingual Clerk	Positions taken in from other agencies	Victor Valley

These recommendations are based on the number of Latino clients accessing the clinic; the amount spent on outside interpreter services, number of bilingual staff and region demographics.

- Create new positions from Outside Interpreter Service savings (Table H) and place them strategically in areas with greater needs (see table F & G).
- Provide intensive training for bilingual staff regarding Interpretation services.
- Include clerical/clinical bilingual staff time for interpreting as part of their every day workload and not in addition to.
- Update SPM regarding Satisfying Consumer Needs to include clear and concise guidelines for using outside services and put a monitor system in place.
- SPM to address length of time using outside interpreter services
- Provide training for current bilingual staff providing interpreter services to address key elements.

In addition to the recommendations above the following is necessary in order to have a better monitoring system:

- Revision of current SPM to address Satisfying Consumer Needs/Interpreter Service policy and procedures with clear and concise instructions on how to use interpretation services.
- CCTRO will develop a form to monitor clinic expenditures and assure policy and procedures compliance (See Attachment C).
- Refer consumers to clinics that can provide the service needed.
- Use staff and regional resources prior to utilizing Interpreter pool.
- Remind Clinic Supervisors and Program Managers that current bilingual staff should be utilized for interpreting specially if they are receiving bilingual pay.
- Clinic Supervisors and Program Managers should incorporate interpreting as a duty for staff receiving bilingual pay as part of their workload and not in addition to.
- CCTRO should be responsible to track and monitor all expenditures that clinics generate and report it to the Director on a quarterly basis.
- Review hiring/recruitment /retention policies of bilingual staff need to provide services to eliminate disparity issues relates to language.

This research highlighted competencies essential to providing skilled mental health interpreting ensuring access to quality mental health services. For too long, untrained bilingual relatives and/or staff have been used to provide interpreting services. This is inadequate in and of itself, and it can lead to retraumatization. Therefore, it is highly recommended to implement one of the recommendations above to ensure that our consumers receive good quality care. The current process of interpretation and translation in DBH is not conducive to providing quality care and is conducive to over spending.

ATTACHMENT 13

COUNTY OF SAN BERNARDINO STANDARD PRACTICE	NO. 9-1.47 BY Lawrence Vasquez, LCSW	ISSUE 05/30/03 PAGE 1 OF 3 EFFECTIVE
DEPARTMENT BEHAVIORAL HEALTH	APPROVED Rudy Lopez, Director	
SUBJECT **SATISFYING CONSUMER LANGUAGE NEEDS**		

I. PURPOSE:

1. To ensure that consumers have access to appropriate linguistic services primarily through qualified Department staff.

2) To establish guidelines for interpreter services including sign language via DBH certified staff.

3) To establish guidelines, including sign language, via outside vendors.

II. GENERAL POLICY:

San Bernardino Behavioral Health Department will work to ensure that non-English speaking beneficiaries, seeking alcohol/drug and specialty mental health services are linked with appropriate linguistic services. Family members are not to be used as interpreters.

III. DEFINITIONS:

Interpretation – Transmission of oral communication from one language to another including sign language.

Threshold Language - Language that has been identified as the primary language, as indicated on the Medi-Cal Eligibility Data System, of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area.

Primary Language – Any language, including sign language, which must be used by the beneficiary to communicate effectively and which is so identified by the beneficiary.

DBH Bilingual staff – DBH staff that has been certified by the county to provide interpretation services. Individual employed by the Department in a job title other than "interpreter" but who is paid as a bilingual staff and who is called upon to provide interpretation services.

Outside interpretation services – Vendors with whom the department has contracted to provide Behavioral Health care interpretation services to limited-English-proficient consumers by the use of specially trained individuals. (Attachment B)

IV. REFERENCE:

1. CCR, Title 9, Chapter 11, Section 1810.410 (b), (4)
2. DMH Information Notice Number 97-14
3. OC/HCA, BHC, Cultural Competency Plan, Phase II Consolidation (Update of 2/1/99)

V. PROCEDURE FOR NON-ENGLISH SPEAKING THRESHOLD LANGUAGE (SPANISH) SERVICES - DEPARTMENT/OUTSIDE VENDORS:

1. When a non-English speaking or hearing impaired beneficiary is identified the assigned staff will contact the supervisor or their designee to utilize clinic, program or region staff to provide interpretation services in a timely manner.

2. If there in no bilingual staff within the region/specialized program available in a timely basis, then outside vendors need to be contacted to determine consumers' needs.

3. Staff will be required to fill out the Outside Vendor Service request Form (Attachment A) and obtain supervisor/or their designee approval prior to the delivery of service.

4. Outside vendor provider needs to return Outside Vendor Invoice (Attachment A) to clinic supervisor or their designee for reimbursement and monitoring purposes. Invoice is to be reviewed and approved by Program Manager prior to reimbursement by the Business Office. Copies are to be forwarded to the Business Office and Medical Records.

5. Program Managers need to submit a monthly Outside Vendor Cost Report (Attachment C) to Cultural Competency and Training Unit to compile a bi-annual report for the Director for budget planning process.

6. All efforts and progressive steps to link the client to appropriate services with language of choice must be documented in consumer's progress notes and Initial Contact Log Form (Attachment D).

7. Use of Contract vendor services will not be approved for ongoing treatment.

When receiving a call:

1) Use conference Hold to place the non-English speaker on hold.
2) Dial: Outside agency 800 number (select from Attachment B).
3) Give information.
4) Brief the interpreter on the purpose of the call and confidentiality requirements.
5) Add non-English speaker to the line.
6) Say, "end of call" to the interpreter when the call is completed.

When placing a call to a non-English speaker, begin at step 2.

VI. RESPONSIBILITY:

1. Each region/specialty program will be provided with a roster of linguistically proficient bilingual staff every six months by Human Resources.

2. DBH Interpreters are required to attend annual training on the delivery of Interpretation services (see DBH Training Update/Schedule).

3. Supervisors will be responsible for equity workload for staff providing interpretation services.

4. Paid bilingual staff within a region/specialty programs are mandated to provide interpretation services.

VII. PROCEDURE FOR NON-THRESHOLD LANGUAGE (Other than Spanish):

1. Refer to Section V to determine consumer needs.

2. Staff will attempt to locate and link consumers with services that are linguistically appropriate. Linkage for services may be within community service organizations, fee for service providers, and contract agencies (see DBH Community Resource Booklet).

3. Use of Contract Vendor services will not be approved for ongoing treatment.

   Exception: Consumer meets DBH target population criteria and has a special language that cannot be provided by DBH certified bilingual staff or Fee for Service Provider.

ATTACHMENT 14

COUNTY OF SAN BERNARDINO STANDARD PRACTICE	NO. 9-1.46 BY Lawrence Vasquez	ISSUE 05/30/03 PAGE 1 OF 4 EFFECTIVE
DEPARTMENT BEHAVIORAL HEALTH	APPROVED Rudy Lopez, Director	
SUBJECT **Translation Policy of Written Materials**		

I. PURPOSE

- To provide standards and guidelines for translating consumer informational materials, forms, and any other written documents into another language.
- To ensure that all consumer information materials, forms and any other written documents are translated into the threshold language identified by the department of Behavioral Health (DBH) based on the state criteria.
- To monitor quality, distribution and availability of translated informational materials, forms and any other written documents for DBH sites.

II. POLICY

- All written information, forms, and documents created for consumers must be translated to the threshold language identified by DBH.
- All translated written information, forms and documents must follow translation standards.
- All written information, forms and documents created for consumers, will be field tested.
- All translated written information materials and forms, must be reviewed and approved by the Cultural Competency and Training Unit prior to distribution.
- Copies of translated materials will be housed Cultural Competency Training Unit.

III. DEFINITION OF TERMS

Translation: Transmission of written communication from one language to another.

DBH Bilingual Staff: DBH staff certified by the county to provide translation services. Individuals employed by the department in a job title other than "translator" but who are receiving bilingual pay and who are called upon to perform the role of translator. A list of bilingual staff is available through Payroll upon request.

Outside Translation Services – Vendors that provide translation services. (Attachment A, list of vendors)

Threshold Language- Language identified as the primary language, as indicated on the Medi-Cal Eligibility Data System of 3,000 beneficiaries or five percent of the beneficiary population.

Primary Language- Any Language, including sign language, which must be used by the beneficiary to communicate effectively and which is so identified by the beneficiary.

Back Translation – The translated document will be translated back to English. This procedure ensures that the content of the original English version is maintained.

IV. REFERENCE

1. CCR, Title 9, Chapter 11, Section 1810.410 (b), (4)
2. DMH Information Notice Number 97-14
3. OC/HCA, BHC, Cultural Competency Plan, Phase II Consolidation (Update of 2/1/99)

V. Translation Procedures

A. Translation by Department of Behavioral Health staff

1. Clinic/Program staff develop or identify material(s) to be translated.

2. Prior to translation Cultural Competency and Training unit must be contacted to find out if material(s) have been translated. If material(s) have been translated copies of the material will be sent

3. If the material(s) to be translated are not available in the language needed, the Translation Request Form must be completed and submitted to the supervisor for approval in order to ensure the following translation procedures are being adhered to: (See attachment B)

   - Two qualified DBH bilingual staff must translate written material(s) and confer with each other to provide first draft from English into the requested language.
   - Back translation must be done to the English version by another bilingual staff to ensure that the content of the first draft was preserved.

   Note: Procedure exception: One-time materials (i.e. flyers, small posters etc.) can be developed by the region/program without review by Cultural Competency and training unit.

4. Material(s) will be submitted to Cultural Competency and Training unit for field testing after procedures 1, 2 and 3 have been completed. Material(s) must be typed and set in the desired format prior to submission to Cultural Competency and Training unit.

5. Field-testing of the second draft will be conducted by Cultural Competency and Training unit, in the community, and with DBH target population.

   - The timeframe for field testing is no more than one month after receiving the written request.

B. Translation By Cultural Competency and Training Unit

1. Translation Request Form must be completed by supervisor and submitted to Cultural Competency and Training Unit for approval.
2. Translation process will be completed within one month after request has been received.

C. Distribution

The final version of the translated material(s) will be distributed by the Cultural Competency and Training Unit. A copy of all translated material(s) will be housed in CCTRO.

VI. Responsibilities

1. Human Resources will provide region/specialty programs with a roster of linguistically proficient bilingual staff upon request.

2. Qualified DBH bilingual staff is required to attend annual training on translation services.

3. Staff providing translation services are required:

   - To be proficient in English and the language in which the material will be translated to.
   - Ability to distinguish between technical language and common language of prospective consumer/audience.
   - To be familiar with common language of both cultures to increase translation accuracy.

4. Supervisors will be responsible for ensuring equity workload for staff providing translation services.

5. Paid bilingual staff within a region/specialty programs will be use for interpreter/ translation services

VII. Outside Vendor for Translation Services

1. DBH region or specialized programs will seek outside vendors only as a last resource, if there is no bilingual staff available, and only after approval is received from Cultural Competency and Training Unit. All requests must be approved by Cultural Competency and Training Unit before contacting vendor for services.

2. Supervisor will send the Translation Request Form to Cultural Competency and Training Unit documenting their efforts of obtaining bilingual staff for translation services within their region/specialty programs.

3. Cultural Competency and Training Unit's Program Manager or designee must approve request for outside vendor for translation service.

4. Field-testing will be conducted in the community and with target population by Cultural Competency and Training Unit after translation is completed by the outside vendor.

5. Cultural Competency and Training Unit will maintain and distribute translated materials.

APPROVED INTERPRETER SERVICE VENDORS/CONTRACTORS

The current contracts are effective 9/10/02 through 9/9/04

Contractor/Vendor	Contract Number
AndAlex International,Inc.	02-913
Asian-American Resource Center	02-914
Language Services Associates	02-915
LifeSigns, Inc.	02-916
New World Language Services	02-917

See attached summary of Translation and Interpretation Services for the above mentioned vendors/contractors.

Translation and Interpretation Services

Summary of Services
Effective 9/10/02-9/9/04

SERVICES	ANDALEX LANGUAGE SERVICES	ASIAN-AMERICAN RESOURCE CENTER	LANGUAGE SERVICES ASSOCIATES	LIFESIGNS, INC.	NEW WORLD LANGUAGE SERVICES
Access Code	1111	DBH	3770	DBH	706309
Languages	Over 80 See Attached	Over 30 See Attached	Over 100 See Attached	Sign and Tactile	Over 200 See Attached
Experience with: Behavioral Problems Abused/Neglected	 Yes Yes	 Yes Yes	 Yes Yes	 Yes Yes	 Yes Yes
Availability	24 hr/7 day	***Monday – Saturday*** 8:00 a.m. – 5:00 p.m.	24 hr/7 day	***Monday – Friday*** 7:30 a.m. – 5:00 p.m. Emergency Answering Service 24/7	24 hr/7 day
Regions Served	All – Telephone Only	All	All	All	All
Provides interpretation & translation for sign language.	No	Yes	Yes	Yes	Yes
Has the ability to travel to various County work sites to perform the proposed services.	No	Yes	Yes	Yes	Yes
Has the ability to visit a client's home on occasion.	No	Yes	Yes	Yes	Yes
Be able to provide translation and/or interpretation services on a 48-hour notice.	Yes	Yes	Yes	3-5 working days – depends on day of the week.	Yes

Translation and Interpretation Services

Summary of Services
Effective 9/10/02-9/9/04

SERVICES	ANDALEX LANGUAGE SERVICES	ASIAN-AMERICAN RESOURCE CENTER	LANGUAGE SERVICES ASSOCIATES	LIFESIGNS, INC.	NEW W LANGI SERV
Have access to a Fax machine or e-mail for nslation documents.	Yes 503-246-6002	Yes 909-383-7687	Yes 267-781-0154	No	Yes 909-388
Have a toll-free phone number for interpreter access.	Yes 800-514-9237	Not at this time 909-383-0164	Yes 866-937-7325	Yes 888-930-7779	Yes 800-873
Provide a toll-free Telecommunication Device for the Deaf (TDD).	No	No	No	No	No
Telephone Interpreter	Yes	Yes	Yes	No	Yes
On-Site Spanish	No	Yes	Yes	No	Yes
On-Site Sign	No	Yes	Yes	Yes	Yes
On-Site Other	No	Yes	Yes	Yes (Tactile)	Yes
Written Translation	Yes	Yes	Yes	No	Yes
Braille	Yes	No	No	No	Yes

E:SPM:translationpolidy042903

TRANSLATION REQUEST

Date:_____

Requestor: _____ **Worksite:** _____ **Telephone:** _____

Title of Document: _____

Description of Translation Requested:

- ☐ Letter
- ☐ Informational Material
- ☐ Form
- ☐ Written document
- ☐ Other _____

Language Requested:

- ☐ English
- ☐ Spanish
- ☐ Other _____

Disposition:

☐ DBH qualified staff assigned for translation

- ☐ First draft completed
- ☐ Back translated completed
- ☐ Diskette included

☐ No staff available for translation in region or specialized program.

☐ Translation Request Form completed and forwarded to Cultural Competency and Training Unit for outside vendor.

☐ **Approval** ☐ **Denied**

Justification:_____

_____

_____

_____

Cultural Competency and Training Unit Supervisor
Signature:_____ Date: _____

Translation and Interpretation Services
Summary of Services
Effective 9/10/02-9/9/04

SERVICES	ANDALEX LANGUAGE SERVICES	ASIAN-AMERICAN RESOURCE CENTER	LANGUAGE SERVICES ASSOCIATES	LIFESIGNS, INC	NEW WORLD LANGUAGE SERVICES
Have access to a Fax machine or e-mail for translation documents.	Yes 503-246-6002	Yes 909-383-7687	Yes 267-781-0154	No	Yes 909-388-1796
Have a toll-free phone number for interpreter access.	Yes 800-514-9237	Not at this time 909-383-0164	Yes 866-937-7325	Yes 888-930-7779	Yes 800-873-9865
Provide a toll-free Telecommunication Device for the Deaf (TDD).	No	No	No	No	No
Telephone Interpreter	Yes	Yes	Yes	No	Yes
On-Site Spanish	No	Yes	Yes	No	Yes
On-Site Sign	No	Yes	Yes	Yes	Yes
On-Site Other	No	Yes	Yes	Yes (Tactile)	Yes
Written Translation	Yes	Yes	Yes	No	Yes
Braille	Yes	No	No	No	Yes

E:SPM:translationpolidy042903

INITIAL CONTACT LOG
TELEPHONE, WALK-IN AND WRITTEN REQUESTS FOR SERVICES
SAN BERNARDINO COUNTY - DBH

NAME OF CLINIC_____ **REPORTING MONTH/YEAR**_____

TITLE 9 REQUIRES THAT ALL INITIAL REQUESTS FOR SERVICES MUST BE LOGGED

	DATE AND TIME	** URGENT YES√ NO√	NAME OF CALLER AND RELATIONSHIP TO BENEFICIARY (Last Name, First Name)	NAME OF BENEFICIARY (Last Name, First Name)	INTERPRETER SERVICES OFFERED YES√ NO√ (LANGUAGE)	*** CALLER'S RESPONSE TO OFFER OF INTERPRETER SERVICES	REASON FOR CALL	INITIAL DISPOSITION	**RESPONSE TIME TO OBTAIN URGENT SERVICES	STAFF NAME
1		☐ ☐			☐ ☐					
2		☐ ☐			☐ ☐					
3		☐ ☐			☐ ☐					
4		☐ ☐			☐ ☐					
5		☐ ☐			☐ ☐					
6		☐ ☐			☐ ☐					
7		☐ ☐			☐ ☐					
8		☐ ☐			☐ ☐					
9		☐ ☐			☐ ☐					
10		☐ ☐			☐ ☐					

MHP REQUIRES A MAXIMUM RESPONSE TIME OF 2 HOURS FOR ALL REQUESTS FOR URGENT SERVICES. * ENTER 1) ACCEPTED OR 2) REFUSED

ATTACHMENT A

OUTSIDE VENDOR SERVICE REQUEST FORM

Staff Name:_____ Date Requested:_____

Program/Clinic Name: _____

Date services are needed: _____

Language requested (Including sign language): _____

Consumer Name: _____

Chart Number: _____

TO BE COMPLETED BY SUPERVISOR

Justification for service: _____

_____

_____

_____

Approved:____ Denied: _____

Date:_____ Supervisor's Name:_____

CONTRACT VENDOR INVOICE

Contract Vendor Name:_____ Access Code:_____

Service Date:_____ Charged Time:_____ Service Cost:_____

Provider's name:_____ Date:_____

Signature: _____

White Copy: Business Office
Yellow Copy: Program Manager
Pink Copy: Medical Record

APPROVED INTERPRETER SERVICE VENDORS/CONTRACTORS

The current contracts are effective 9/10/02 through 9/9/04

Contractor/Vendor	Contract Number
AndAlex International,Inc.	02-913
Asian-American Resource Center	02-914
Language Services Associates	02-915
LifeSigns, Inc.	02-916
New World Language Services	02-917

See attached summary of Translation and Interpretation Services for the above mentioned vendors/contractors.

Translation and Interpretation Services
Summary of Services
Effective 9/10/02-9/9/04

SERVICES	ANDALEX LANGUAGE SERVICES	ASIAN AMERICAN RESOURCE CENTER	LANGUAGE SERVICES ASSOCIATES	LIFESIGNS INC.	NEW WORLD LANGUAGE SERVICES
Access Code	1111	DBH	3770	DBH	706309
Languages	Over 80 See Attached	Over 30 See Attached	Over 100 See Attached	Sign and Tactile	Over 200 See Attached
Experience with: Behavioral Problems Abused/Neglected	 Yes Yes	 Yes Yes	 Yes Yes	 Yes Yes	 Yes Yes
Availability	24 hr/7 day	***Monday – Saturday*** 8:00 a.m. – 5:00 p.m.	24 hr/7 day	***Monday – Friday*** 7:30 a.m. – 5:00 p.m. Emergency Answering Service 24/7	24 hr/7 day
Regions Served	All – Telephone Only	All	All	All	All
Provides interpretation & translation for sign language.	No	Yes	Yes	Yes	Yes
Has the ability to travel to various County work sites to perform the proposed services.	No	Yes	Yes	Yes	Yes
Has the ability to visit a client's home on occasion.	No	Yes	Yes	Yes	Yes
Be able to provide nslation and/or erpretation services on a 48-hour notice.	Yes	Yes	Yes	3-5 working days – depends on day of the week.	Yes

Translation and Interpretation Services
Summary of Services
Effective 9/10/02-9/9/04

SERVICES	ANDALEX LANGUAGE SERVICES	ASIAN AMERICAN RESOURCE CENTER	LANGUAGE SERVICES ASSOCIATES	LIFESIGNS, INC	NEW WORLD LANGUAGE SERVICES
Have access to a Fax machine or e-mail for translation documents.	Yes 503-246-6002	Yes 909-383-7687	Yes 267-781-0154	No	Yes 909-388-1796
Have a toll-free phone number for interpreter access.	Yes 800-514-9237	Not at this time 909-383-0164	Yes 866-937-7325	Yes 888-930-7779	Yes 800-873-9865
Provide a toll-free Telecommunication Device for the Deaf (TDD).	No	No	No	No	No
Telephone Interpreter	Yes	Yes	Yes	No	Yes
On-Site Spanish	No	Yes	Yes	No	Yes
On-Site Sign	No	Yes	Yes	Yes	Yes
On-Site Other	No	Yes	Yes	Yes (Tactile)	Yes
Written Translation	Yes	Yes	Yes	No	Yes
Braille	Yes	No	No	No	Yes

ATTACHMENT C

OUTSIDE VENDOR COST REPORT

Month of:_____/_____

Program Manager Name:_____

Region/Specialty Service Name:_____

Contract Vendor Service Log

Date of Service	Services Provided	Language Requested	Site Location	Consumer Name/Chart #	Vendor Name	Cost of Service

Interpreterspm 030603 cont agency intersvslog

ATTACHMENT 15

Attachment #15

INTEROFFICE MEMO

DATE: August 7, 2003 **Phone:** (909) 854-3448

FROM: **Myriam Aragon, CT II**
Cultural Competence and Training Unit

TO: **Program Managers and Clinic Supervisors**

CC: **Rudy Lopez, Director**
Lawrence Vasquez, Program Manager II

SUBJECT: Building Inspection – Cultural Competence

The following information is to prepare your clinics for the Annual Review scheduled and to be in compliance with Cultural competence requirements regarding Linguistic Services

1. After hours and regular hours phone message needs to be in both English and Spanish. It is also recommended to have the same message posted in the clinic's front door. Yes____ No____
2. Posters regarding Consumer Guide with big letters for beneficiaries with visual impairment need to be displayed in the waiting area. Yes____ No____
3. Consumer Guide Video tape and clinic protocol on how your consumers will get to see the video needs to be available at each clinic. Yes___ No___
4. Brochures regarding service and mental health information in both English and Spanish are available in the waiting area. Yes___ No___
5. Your staff is familiar with interpretation/translation SPM and protocols in your clinic to provide interpretation training. Staff is to be aware of Interpretation Line and how to use it. Yes___ No___
6. All staff is to be aware and have access of the FFS provider's list. Yes___ No___
7. All staff is aware and has access to in-house bilingual staff list, and have knowledge of alternative options for cultural and linguistic services. Yes___ No____
8. Poster informing consumers that they have the right to free language assistance services is in the waiting area in English and Spanish. Yes____ No_____
9. All staff is to be familiar and have accessibility to the Change of Providers forms. Staff will be interviewed in regards to the process of changing providers per client's request. The form needs to be available in both English and Spanish. Staff needs to know where the forms are located and be familiar with protocol regarding change of providers SPM. Yes___ No____
10. Clinic supervisors are to ensure that the provision of services in the client language other than English is documented in the client's record. Yes____ No____
11. Documentation in the charts of consumers that are required services in languages that are not our threshold language. (i.e. charts of consumers that speak languages other than English and Spanish). Yes___ No____

(The Cultural Competence Unit will conduct Side inspections randomly)

ATTACHMENT 16

Providing Interpretation Services
DBH Training Program for Staff Providing Interpretation Services

Myriam Aragón, LMFT
Clinical Therapist II
Cultural Competence & Training Unit

Agenda

1:00- 2:00	Introduction Review of Title VI Bilingual Fluency Exercise I (Slide 1-6) Questions
2:00- 2:15	Break
2:15-3:30	Cultural Knowledge Ethical dilemmas (Slide 7-11) Questions
3:30-3:45	Break
3:45- 4:55	The Therapeutic Triad The Therapeutic Relationship (Exercise II) Providers Guideline Interpreters Competencies The interpretation in Mental Health Interpreter Style Questions
4:55-5:00	Evaluation

Providing Interpretation Services

San Bernardino Behavioral Health

Presenter

Myriam Y. Aragón, LMFT

The provision of interpretation services is a complex one. The interpretation services include both the verbal and non-verbal communication in the context of the individual and family's culture. The task of the bilingual staff providing interpretation services require the unique combination of cognitive/academic language abilities in English and another language. The bilingual staff providing interpretation services needs to know the content and context of the conversation in the English language and the content and context of the conversation in the other non-English language, the specialized terms and concepts in both languages, and the ethics of interpreting. The staff using interpretation services needs know how to help the interpreter to establish a good working relationship with the consumer.

This training is design for staff who provide interpretation services, and staff who use interpreters to provide their services.

Learning objectives:

1. Understanding the fundamental principles for the use of Interpreter.
2. Developing a team/partner relationship with your interpreter.
3. Understanding the limitations and benefits in the use of interpreters.
4. Understanding the roles of both the staff using interpreters and the interpreters when services are provided.
5. Understanding the protocols and ethics of interpreting

Providing Interpretation Services

Myriam Y Aragón, LMFT
Clinical Therapist II
Cultural Competence & Training Unit

1

The Art of Interpretation

Interpretation: Transmission of **Oral** communication from one language to another.

Simultaneous Interpretations: As one party speaks, the interpreter is interpreting to the other.

(two people is always talking at once)

Consecutive Interpretation: The interpreter waits until one party finishes and then interprets to the other (only one person speaks at a time).

2

The Law

- Title VI of Civil Rights Act of 1964: Medical facilities receiving federal funds must provide equal services to all people, even if they do not speak English.
- Presidential Executive Order August 2000: Federally funded programs must serve people with limited English Proficiency(LEP)
- CLAS Standards publish 2001: "Culturally and Linguistically Appropriate Services"

3

Title VI

Civil Right Act of 1964 with respect to the enforcement of the responsibilities of recipients of Federal financial assistance form Health and Human Services to persons with Limited-English Proficiency (LEP) (Review of Guidance Memorandum)

4

Equal Access to LEP Persons

It is the agency's responsibility to ensure we have policies and procedures to provide equal access to services.

- Have procedures to identify the language needs
- Have ready access in a timely manner, using interpreters as a last resource.
- Develop Policies and procedures

5

Meeting Title VI

- Hire bilingual staff
- Hire staff interpreters
- Use volunteer staff interpreters
- Arrange for services of volunteer community members
- Contract with outside interpreter service
- Use telephone interpretations line/ outside vendors

6

Bilingual Fluency

- The Interpreter must be fluent in two languages, one of them English. The interpreter should be able to speak, understand, and write both languages fluently.

Exercise I (20 minutes)

7

Cultural Knowledge

- The Interpreter must be culturally competent in all cultures he or she interprets for. (Interpreters is not only a language broker but also a cultural broker)

Modismos/ Idioms

Context

Content

Non-Verbal/ body expression

(Hand out example, and discussion)

8

Language

- Language use is affected by:
  - Regional variations
  - Social Class
  - Education
  - Migration
  - Multiculturalism

9

What do we need to know?

- Differences in cultural conceptualizations of illness/health and help-seeking.
- Differences in language and communication patterns.

10

Ethical Dilemmas

- Protection of consumers well being.
- Protection of confidentiality
- Accuracy . No information may be added or omitted.
- Interpreters must not provide advice or give their own opinions. The treatment remains providers responsibility.

11

Ethical Dilemmas

- **Neutrality**: The interpreter needs to remain neutral and should not screen the client's comments or messages for fear of offending the provider, or because it may reflect poorly on the consumer.
- **Limits of expertise**: Interpreter must ask for clarification immediately if she/he does not understand either the provider or the consumer

12

The Therapeutic Triad

The interpreter must be skilled in facilitating communication between the consumer and the provider without becoming a barrier to building a treatment relationship.

The provider must be skill in conducting his intervention by using interpreters to facilitate the process of interpretation

13

Three way communication

Relationships sets:

Provider ↔ Interpreter (Professional)

Provider ↔ Patient (therapeutic/Treatment)

Interpreter ↔ Patient (interpreter)

- Verbal communication at any one time.
- Non-verbal communication at all times.

14

Provider ↔ Interpreter

- It is important for both the provider and the interpreter to discuss the expectations, setting arrangements, consumer's language needs, provider's interviewing style, cultural information and consideration regarding the consumer data.
- Discussed matching between interpreter and consumer on age, sex, country of origin, cultural background, etc. that may affect the consumer's disclosure.

15

Provider ↔ Consumer

The therapeutic Relationship

- The Provider and the consumer need address each other directly. It is recommended to face each other.
- The interpreter needs to use the same form of speech as the speaker– first person.

(example ~~3~~. Exercise ~~3~~ 4)

16

Interpreter ↔ Consumer

- Informed the client that the interpreter function is to guarantee the right of the consumer to consult with the provider in as direct manner as possible.
- Do not talk about the consumer on their presence. If you need clarification from the provider, explain to the consumer what you will be doing.

17

Providers Guidelines

- Talk directly to the consumer.
- Learn and use a few phrases of greeting and introduction in the client's native language.
- Become as familiar as possible with the client's cultural background.
- Use language within the ability/ knowledge level of the interpreter and the consumer.
- Regulate the pace of the interview. Keep sentences brief and concise. Ask questions or explain with simple, short sentences.
- Avoid chained questions.
- Advice the consumer of possible interruptions to clarify his/ her responses and to allow the interpreter time to interpret answers.
- Anticipate extra time needed.

18

Providers Guidelines

Points to check when you are using interpreters

- Is the client prevented from telling you everything because of his/her relationship with the interpreter?
- Is the client embarrassed by the interpreter?
- Does the interpreter tell you when he/she is having difficulty and why?
- Are you controlling the conversation?
- Be aware of the limitation of the information gathered through an interpreter, and allow extra time for redundant questioning and fact finding. The examiner should ask the interpreter to translate back to the client what the interpreter has told the examiner,and observe the reaction of the client.

19

Interpreters Competencies

- Must be familiar with the mental health setting and the mental health system.
- Must be familiar with the vocabulary specific to mental health services.
- Must be familiar with the terminology of the interpretation/ or with sight translation.

20

The interpretation in Mental Health

- Interpreter should be familiar with the terminology in both English and the non-English language, such:
  - Diagnosis and symptoms
  - Medications and side effects
  - Terminology used on the different forms that a consumer is required to complete and/or sign.
  - Need to ask the provider to describe the concept in different words.

21

Terminology of Interpretation

- A-language: The language that the interpreter is most comfortable with. Most often is the language the person was raised.
- B-Language is the interpreter's second language.
- Target language is the language the interpreter interprets to.
- Source language is the language the interpreter interprets from
- Sight Translation: Interpreter translates a document from written to spoken language.

22

Interpreter Style

- **Consecutive interpretation**: One person speaks at a time. The speaker speaks in short sentences. When the speaker finished, the interpreter interprets.
- It is the most common/ and recommended in mental health.
  - For interpreters who do not have many year of training.
  - Less confusing for the consumers

23

Interpreter Style

- **Simultaneous Interpreting**. It means the interpreter follows just a few words behind the speaker. Both the interpreter and the speaker are speaking at the same time.
- It is recommended when the client is not able to speak in short sentences and cannot stopped to give the interpreter time to interpret.

24

Interpreter Style

- **Relay Interpreting**: It is the technique use when is the only way to communicate with the client. It is use when the client speak a language which no bilingual staff is found. In this case two interpreters are needed.

Consumer speak Portuguese

Interpreter 1 interpreters Portuguese to Spanish

Interpreter 2 interpreters Spanish to English

25

Post-Session

Debriefing the session is very important to clarify possible cultural and linguistic communication barriers. Additionally, if the staff person providing the interpretation is /has been the client's counselor or case manager, the post session provides an opportunity for the staff person to make observations based on his/her relationship with the client.

1. Discuss questions/concerns that emerged during the session (bring out communication problems , discuss cultural issues and the interpreter's impressions of the client's use of the language, etc
2. Debrief with interpreter. Special sensitivity may be needed regarding painful memories, and or emotional issues related to the client's situation/ traumatic events. (Refugees)
3. Make plans/ arrangements for future sessions.

26

ATTACHMENT 17

County of San Bernardino
Department of Behavioral Health
List of off- site Program

- **PRO** Collaboration efforts with Probation Department.

- **Forensic Services**: JMHS Jail Mental Health Services
  STAR Supervised Treatment After Release
  STAR-LITE Less Intensive Treatment Environments
  SPAN San Bernardino Partners Aftercare Network
  PASSAGES
  JJOP Juvenile Justice Outpatient Program

- **Cal-Works**: all the Cal- work programs are located at TAD or JESD offices: Rancho Cucamonga, Ontario, San Bernardino, Redlands, Fontana, Colton, Victorville, Hesperia and Morongo.

- **School Based Services:** Mental health services are provided at school sites thought the county.

- **SELPA/ AB2726:** San Bernardino Department of Behavioral Health provides services to all the children referred by the Special Education Local Plan Areas (SELPA). The services include residential assessment, treatment and case management.

- **CCICMS:** In home and Hospital team provides treatment and case management services to children being discharged from ARMC-BH to their homes, and intensive treatment and case management to those at risk for re-admission or placement at a higher level of care.

- **CSOC:** CSOC is a program focusing on the inter-agency coordination and case management of children who are in or at risk of being placed in Level 11-14 group homes, SHAC or Metro State Hospital.

- **Age Wise:** the program is a prevention program for seniors age 55 and older who are experiencing depression, sadness, loss, anxiety and/or adjustment to issues concerning seniors. The program serves all of San Bernardino County. The service includes in-home assessment and services at senior centers in the community.

- **Homeless Program:** (AB2034) Provides outreach, case management, shelter/residential and medication support services to mentally ill adults who are at risk of incarceration or hospitalization. The Services are provided in community agencies, inpatient units, and community homeless shelters.

- **Boy's and Girl's Club Community Counseling Center:** Located at the Boys and Girls club in San Bernardino. Provides a wide range of mental health services to a diverse population

- **Wraparound Services for Children:** Intensive services directed toward " at risk" children. DBH has three Wraparound programs:
  FICS: High Desert
  Pacific Clinics: Morongo Basin
  Project Affirm: Central & West Valley